



**2017 STUDENT FLU SHOT CONSENT FORM**

**PLEASE PRINT - All fields are required**

<b>Official Use Only</b>	Vaccine Source: VFC	KCHD	
	Vaccine Naïve:	No	Yes
	Vaccine Type:	IIV: 6-35m	36m+
		Phase 1	Phase 2

Student's Name - First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

School: \_\_\_\_\_ Home Room Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Gender:  Male  Female Primary Language: \_\_\_\_\_ Hispanic:  Yes  No

Race:  White  Black  Asian  American Indian  Alaskan Native  Other: \_\_\_\_\_

**Primary Insurance (Select One):**  CoverKids  TennCare  Private Insurance  No Insurance

Primary Insurance Name: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Insurance Address/P.O. Box: \_\_\_\_\_ Insurance ZIP Code: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**Secondary Insurance (Select One):**  CoverKids  TennCare  Private Insurance  No Secondary Insurance

Secondary Insurance Name: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Insurance Address/P.O. Box: \_\_\_\_\_ Insurance ZIP Code: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**Please answer YES or NO to all questions. Answers are for the person receiving the vaccine.** **Circle** for each question

**\*\* This flu vaccine is a shot \*\***

1. Has your child received at least 2 doses of FLU vaccine during his or her lifetime? If unsure, mark No.	Yes	No
2. Has your child ever had a severe or life threatening allergic reaction to the flu vaccine such as wheezing or breathing problems? If yes, describe reaction:	Yes	No
3. Is your child allergic to eggs? If yes, describe reaction:	Yes	No
4. Has your child ever had Guillain-Barre´ syndrome?	Yes	No
5. Does your child faint when they get a shot?	Yes	No

**Consent for Administration of Influenza Vaccine for the above named recipient:** I have read information about the vaccine and special precautions on the Vaccine Information Sheet. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to the person above of whom I am parent or legal guardian, and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release Knox County Government, their affiliates, employees, directors and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination. This consent gives Knox County Health Department permission to file rendered services to your insurance carrier. Consent form is valid 6 months from date of initial signature. For a copy of the Vaccine Information Sheet visit [http://www.immunize.org/vis/flu\\_inactive.pdf](http://www.immunize.org/vis/flu_inactive.pdf).

**PARENT COMMENTS:**

Parent /Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Primary Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Emergency Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

**Official Use Only**  
Place **Phase 1** Nursing  
Record Sticker Here  
Align with right side of this box

**Official Use Only**  
Place **Phase 2** Nursing  
Record Sticker Here  
Align with left side of this box