If you want your student vaccinated for the FLU, complete and return this form to your child's homeroom teacher or you can fill it out online at http://knoxcounty.org/health/schoolflu. If you do not want your child vaccinated, do not fill out either form. **ABS** **REF**

Knox County Health Department — Every Person, A Healthy Person

2019 Student FLU Vaccine Consent Form

PLEASE PRINT in ink - All fields are required

Official Use Only	**Vaccine Source:** VFC KCHD **Vaccine Naïve:** No Yes **Vaccine Type:** FluMist ≥ 2 yr	

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 Hispanic: ☐ Yes ☐ No Primary Language: _____

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 Circle Yes or No for all questions. Answers are for the person getting the vaccine.		
1. Has your child had at least 2 doses of FLU vaccine during his or her lifetime? If unsure, mark No.	**Yes**	**No**
2. **In the past 30 days**, has your child had a vaccine for MMR, Varicella (Chicken Pox), or Yellow Fever? **Name of Vaccine(s):** **Date(s):**	**Yes**	**No**
3. 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**
4. Is your child allergic to vaccine components such as eggs, gentamicin, arginine, gelatin, or MSG? **If yes,** describe reaction:	**Yes**	**No**
5. Has your child ever been diagnosed with Guillain-Barre´ syndrome or any other neurological/neuromuscular disorders?	**Yes**	**No**
6. Does your child have any of the following: (Please mark all that apply) ___chronic heart diseases ___diabetes/metabolic diseases/disorders ___blood diseases ___kidney diseases/disorders ___asthma/reactive airway disease/wheezing ___an inhaler that is used regularly ___liver disorders ___weakened immune system, cancer, lupus or HIV/AIDS ___a medication that lowers the body's resistance to infection	**Yes**	**No**
7. Is your child pregnant?	**Yes**	**No**
8. Is your child on long-term aspirin therapy or taking Tamiflu®, Relenza®, amantadine, or rimantadine?	**Yes**	**No**
9. Does your child have close contact with severely immunocompromised persons who require a protective environment?	**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_live.pdf.**

PARENT COMMENTS:

Parent /Guardian Signature: _____ Date: _____

Parent/Guardian Name: _____ Relationship to Student: _____

Primary Phone: ( ) _____-_____ Emergency Number: ( ) _____-_____ Revised 8/20/19

Phase 1- Official Use Only

Drug Name: _____ VFC KCHD

Mfr: _____ NDC: _____

LOT: _____ EXP: _____/_____/_____

VIS Date: ____/_____/_____ Site: _____ Route: _____

Amount: _____ Date Given: _____/_____/_____

Signature: _____ Provider ID: _____

Phase 2- Official Use Only

Drug Name: _____ VFC KCHD

Mfr: _____ NDC: _____

LOT: _____ EXP: _____/_____/_____

VIS Date: ____/_____/_____ Site: _____ Route: _____

Amount: _____ Date Given: _____/_____/_____

Signature: _____ Provider ID: _____