Tennessee Department of Health School Located Influenza Vaccination Project
Student Consent Form & Influenza Documentation Form

If you want a Flu Vaccination given to your child, COMPLETE THE INFORMATION ON THE FRONT AND BACK OF THIS FORM AND SIGN. If NO, stop here and discard the form

Please Print

School:		Home Room Teacher:	Grade:
Student Last Name:		First Name:	MI:
Sex: ❑M ❑F	DOB: / /	Current Age:	
Race: ❑Asian ❑Black ❑Native American ❑Pacific Islander ❑White ❑Other:		Ethnicity: Hispanic ❑Yes ❑No	
Address:	City:	State:	Zip:
Parent/Guardian Last Name:		First Name:	MI:
Parent Guardian Home Phone:		Cell Phone:	

ALL QUESTIONS MUST BE COMPLETED BY CHECKING YES OR NO IN ORDER FOR THE STUDENT TO RECEIVE A FLU VACCINE
The Nurse giving the vaccination will review the information on vaccination day.

1.	Has your child ever received a flu vaccine?	❑Yes	❑No
	If yes, when:		
2.	Has your child received at least 2 seasonal influenza (flu) vaccine doses prior to last July 1?	❑Yes	❑No
3.	Has your child ever had a serious reaction to the flu vaccine in the past?	❑Yes	❑No
	If yes, when:		
4.	Does your child have any allergies to food or medicine?	❑Yes	❑No
	If yes, list allergies:		
5.	Does your child have an allergy to any components of the flu vaccine?	❑Yes	❑No
6.	Has your child ever had Guillain-Barre´ syndrome? (Muscle weakness, reflex loss and numbness or tingling in any part of the body	❑Yes	❑No
7.	Has your child received any other vaccinations in the past 4 weeks?	❑Yes	❑No
	Name of vaccine(s): Where: Date Given:		
8.	In the past 12 months, has a healthcare provider told you that your child had wheezing or asthma?	❑Yes	❑No
9.	Does your child have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes) or anemia or another blood disorder?	❑Yes	❑No
10.	Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	❑Yes	❑No
11.	In the past 3 months, has your child taken medications that weaken the immune system, such as cortisone, prednisone or anticancer drugs; or have they had radiation treatment?	❑Yes	❑No
12.	Does your child live with or expect to have close contact with a person whose immune system is severely compromised, and who must be in a protective isolation, (e.g., such as isolation room for a bone marrow transplant?	❑Yes	❑No
13.	Is your child receiving aspirin therapy or aspirin containing therapy?	❑Yes	❑No
14.	Is your child receiving any prescription medications to prevent or treat flu?	❑Yes	❑No
	If yes, list:		
15.	Is your child pregnant or does she expect to be pregnant within the next month?	❑Yes	❑No

Additional notes:

Request for Administration of Influenza Vaccine for the above named recipient: I received information about the vaccine and special precautions on the Vaccine Information Sheet prior to my child receiving the vaccine and on the day of vaccination. 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 Tennessee Department of Health, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

I understand that this document will be given to and retained by the Tennessee Department of Health. I give permission for my child's school to retain a copy if needed. I acknowledge that I have been given the Department of Health's Notice of Privacy Practices.
This Consent Form is valid for administration of influenza vaccinations for twelve (12) months. It may be used to administer a second dose of influenza vaccine, if needed. I understand that I should report any changes of the above information to the health department prior to vaccination.

Parent/Guardian Signature: _____ **Date:** _____

PLEASE COMPLETE BACK OF FORM

Parents: Please answer questions below for all students under age 19 yrs to determine if your child might be eligible for the Vaccine for Children (VFC) program.

Does your child have TennCare, CoverKids, or any type of private medical insurance? ❑Yes ❑No

If yes, please complete the insurance information below:

Patient's SSN: _____

TennCare ID#:_____

Please circle your TennCare insurance provider
BlueCare/TennCare Select United Healthcare Amerigroup

Name of Insurance Plan:_____ Does insurance cover vaccines? ❑Yes ❑No

Policy Number:_____ Group Number:_____

Name of Subscriber: _____ Member ID:_____

Address To File Claims *(Back of card)*:_____ Birth Date of Subscriber: _____

AREA FOR OFFICIAL USE ONLY				
Nursing Immunization Documentation				
VFC Eligible:	❑Yes ❑No			
❑The Child's identity has been confirmed by TDH staff (staff initials) with a minimum of two of the following:				
	❑Child states name	❑Child states DOB	❑Child states parent name on form	❑Child states address on form
❑Child unable to provide 2 identifiers to TDH Staff. The child's identity has been confirmed by responsible school personnel below:				
	Name:		Signature:	
	Title:			
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#1	Manufacturer:	❑Sanofi	❑GSK	❑Seqirus
		❑AstraZeneca	❑Other:	
VIS Date: / /	Site Administered:	❑Right Deltoid 0.5mL IM	❑Left Deltoid 0.5mL IM	❑Intranasal 0.2mL
Lot number:	Signature:_____ *Signature above indicates immunization given according to PHN protocol*			
Date Given: / /	Provider number:			
#2	Manufacturer:	❑Sanofi	❑GSK	❑Seqirus
		❑AstraZeneca	❑Other:	
VIS Date: / /	Site Administered:	❑Right Deltoid 0.5mL IM	❑Left Deltoid 0.5mL IM	❑Intranasal 0.2mL
Lot number:	Signature:_____ *Signature above indicates immunization given according to PHN protocol*			
Date Given: / /	Provider number:			