TEAR
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TOOELE COUNTY HEALTH DEPARTMENT

SCHOOL FLU CONSENT FORM

Student Name:	Grade:	Teacher:	School:
Address:	City:	State:	Zip:
Phone:	Date of Birth:	Age:	Race:	Sex:
Cell:	May we text you? Yes No	E-Mail:	

Insurance Name:	Member ID #:	Group #:
Policy Holder Name:	Policy Holder Birthdate:	

Secondary Insurance Name:	Member ID #:	Group #:
Policy Holder Name:	Policy Holder Birthdate:	

The person receiving the vaccine:

Yes	No	
☐	☐	has a serious allergy to any foods or medications
☐	☐	has had a serious reaction to a vaccine in the past.
☐	☐	is on aspirin therapy, chemo/radiation therapy.
☐	☐	has been paralyzed by Guillain-Barre Syndrome.
☐	☐	has had immunizations in the last month. If yes, what?_____
☐	☐	has been sick in the last week, on an antibiotic or antiviral medication.
☐	☐	is pregnant, or has a chronic illness such as heart disease, lung disease, diabetes, asthma, kidney or liver disease, anemia or other blood disorder.

I have reviewed and/or had explained to me the information in the Vaccine Information Statement dated 8/7/15. I understand the benefits and risks of the vaccine and request that the vaccine be given to me or the person for whom I am authorized to make this request. I agree that this information may be shared with schools, daycare centers, healthcare providers and others when medically necessary. I have been given a copy of the Notice of Privacy Practices and have had a chance to ask questions. I understand it is my responsibility to know what my insurance plan covers and agree to pay the portion not covered by my insurance. I understand that if the Health Department does not have a contract with my insurance company, or payment is denied, I am responsible for all charges incurred.

Client/Guardian Signature: _____ Date: _____

If paying by credit card please fill out below:
[ ] Visa [ ] Mastercard [ ] Discover [ ] American Express

Card# _____ Exp. Date _____

Amount $ _____ Signature _____

***** *Space Below for Public Health Nursing Information Only* *****

SL VFC/Private preserve <3
IM lateral thigh ☐L ☐R 0.25ml
Lot # _____

SL VFC/Private >3
☐Deltoid ☐L ☐R 0.5 ml
☐Lateral thigh ☐L ☐R 0.5 ml
Lot # _____

Flu Mist>2
☐VFC
☐Private
Lot#_____

Nurse:_____ Amount Paid _____

TEAR

7/31/2018