TEAR

⇦

Parental Preference MIST ☐ INJECTION ☐

Depending on vaccine availability, insurance coverage and CDC guidelines, the nurse will make final determination which vaccine will be given to student.

TOOELE COUNTY HEALTH DEPARTMENT

SCHOOL FLU CONSENT FORM

Student's Name:	Grade:	Teacher:	School:
Address:	City:	State:	Zip:
Cell Phone:	Date of Birth:	Age:	Race:	Gender:
May we text you? YES NO	E-Mail:		
Primary 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 8/7/19. 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 reviewed and/or had explained to me the Notice of Privacy Practices and have had an opportunity 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: _____

Credit Card Payment Option: [ ] Visa [ ] Mastercard [ ] Discover [ ] American Express

Card #_____ Exp. Date _____

Amount $_____ Signature_____

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

VFC/Private >6 months
☐Deltoid ☐L ☐R 0.5 ml
☐Lateral thigh ☐L ☐R 0.5
Lot # _____

Flu Mist>2
☐VFC
☐Private
Lot#_____

Nurse:_____ Amount Paid _____