

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:

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | has a serious allergy to any foods or medications |
| <input type="checkbox"/> | <input type="checkbox"/> | has had a serious reaction to a vaccine in the past. |
| <input type="checkbox"/> | <input type="checkbox"/> | is on aspirin therapy, chemo/radiation therapy. |
| <input type="checkbox"/> | <input type="checkbox"/> | has been paralyzed by Guillain-Barre Syndrome. |
| <input type="checkbox"/> | <input type="checkbox"/> | has had immunizations in the last month. If yes, what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | has been sick in the last week, on an antibiotic or antiviral medication. |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 _____