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

| | | | | |
|---|---|---|---|---|
| Patient's Name: | Grade: | Teacher: | School: | |
| Address: | City: | State: | Zip: | |
| 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, please name_____ |
| ☐ | ☐ | 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 8/6/21. 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. (See attached parent letter.)**

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 0.5ml
Lot # _____

**Flu Mist>2**
☐VFC
☐Private
Lot#_____

Nurse:_____ Amount Paid _____