2024 SCHOOL FLU SHOT SCREENING & CONSENT

FLU SHOTS ARE AVAILABLE FOR 3RD – 12TH GRADE ONLY

Student's First Name: ___________________________ Last Name: _____________________________ Middle Initial: ____________

Date of Birth: ____________________ Age: ______ Sex: Male or Female

Address: ____ City:_________________________________, IA Zip: ________________

School/Building: _________________________________ Grade: ____________ Teacher: __________________________________

Name of Parent(s)/Guardian(s): ______________________________________ Mother's Maiden Name: _____________________

Parent's phone: ______________________________ Child's Doctor/Clinic: ____

Check the box that pertains to this child: **Please provide copy of insurance card with consent form**

Is enrolled in Medicaid (Title 19)

Choose your Medicaid provider: Iowa Total Care or Wellpoint or Molina Medicaid # ________________________

Is enrolled in Hawk-i

Choose your provider: Iowa Total Care or Wellpoint or Molina Insurance ID # _________________________

Does not have any health insurance (no charge)

Has health insurance that DOES NOT pay for flu vaccines (no charge)

Is American Indian or Alaskan Native (no charge)

My child has insurance that pays for vaccine. **Choose one:** Wellmark BC/BS or Other: _________________________

Insurance ID # ______________________ Group # _____________Policy holder's name _______________________

Policy holder's date of birth ________________

For Flu shot, continue to answer the questions below by selecting NO or explain if YES.

1. Does the child have allergies to medications, a vaccine component, latex, eggs, or bovine protein? **NO,** if **Yes, explain** _______________________
2. Has your child ever had Guillain-Barre" Syndrome? **NO,** if **YES, explain** ____
3. Has your child ever had a serious reaction to a vaccine in the past? **NO,** if **YES, explain** ____
4. Is this child pregnant or is there a chance she could become pregnant in the next month? **NO,** if **YES explain** _______________________________

I agree to the following:

1. I have read or have had read to me, the current Vaccine Information Sheet regarding the Influenza vaccine.
2. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the flu vaccine.
3. To have the child's health insurance billed. If insurance does not pay for the whole amount, I agree to pay the difference.
4. I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.
5. I understand this vaccine will be entered into the State's immunization database called "IRIS".
6. I accept responsibility for seeking medical attention for any problems with this vaccine.
7. *Children younger than 9 may need a second dose in one month if this is their first dose. Please plan to get the second dose at your medical provider office, pharmacy or Public Health. We will not be returning to the school for second doses or for absences on the day that we come to the school.*
8. I fully discharge, their offices, directors, and employees from any liability for illness or damage which may result there from.
9. I agree and understand that by signing the Electronic Signautre Acknowledgment of Consent Form that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement.

I give permission for my child to receive the Influenza vaccine (Flu shot)

Signature of parent/guardian: ____________________________________ Date: ____________________

Return this form to school by September 6, 2024

OFFICE USE ONLY

Is the child sick today? **NO,** If **YES, explain**____

Date:	**VFC** or **Private**	**Lot #**	Site: RA LA RT LT Dose: .5cc .25cc IM	Provider Signature:

DATE in IRIS: _____________ INITIALS: __________