Public Health
Prevent. Promote. Protect

2026 School Flu Shot Screening & Consent Form

3rd – 12th Grades Only

Students First Name: _____ MI: _____ Last Name: _____

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: _____

Child's Insurance ***(Please provide copy of insurance card with consent form)***

☐ **Medicaid**
Circle: Iowa Total Care / Molina / Wellpoint / Other: _____ Medicaid # _____

Hawk-i
Circle: Iowa Total Care / Molina / Wellpoint / Other: _____ Insurance ID # _____

☐ Does **NOT** have any health insurance
☐ Has health insurance that **DOES NOT** pay for flu vaccines
☐ Is American Indian or Alaskan Native
☐ My child has insurance that pays for vaccine. Insurance Name: _____
Insurance ID # _____ Group # _____
Policy holder's name _____ Policy holder's date of birth_____

Vaccine Screening *(Please circle)*

History of Guillain-Barré Syndrome? YES / NO

History of serious allergic reaction to a vaccine? YES / NO If YES, please explain: _____

Is the patient pregnant or potentially pregnant? YES / NO If YES, please explain: _____

I acknowledge that I have received and reviewed the current Vaccine Information Statement (VIS) for the influenza vaccine. I have had the opportunity to ask questions regarding the vaccine and understand its potential benefits and risks. I authorize the administration of the influenza vaccine to the patient named above. I authorize release of medical and insurance information necessary for claims processing and assignment of insurance benefits for payment of vaccination services. I understand that I am financially responsible for any balance not covered by insurance.
I understand and acknowledge that:

- Vaccination information will be entered into the State Immunization Registry Information System (IRIS).
- Adverse reactions or side effects may occur following vaccination.
- Children younger than 9 years of age receiving influenza vaccine for the first time may require a second dose.
- The clinic, school, and associated personnel shall not be held liable for adverse outcomes except as provided by applicable law.

I give permission for my child to receive the Influenza Vaccine (Flu Shot)

Signature of Parent/Guardian: _____ Date: _____

Office Use Only

Date:	☐ VFC ☐ Private	Vaccine Sticker	Site: ☐ IM ☐ RD ☐ LD ☐ RVL ☐ LVL	Administered by: ☐ Becky ☐ Kelli ☐ Kathy ☐ Emily	IRIS: _____ Billed: _____ Paid: _____ ☐ Taylor ☐ Adams ☐ Ringgold