

		PARENT CONSENT FOR SEASONAL INFLUENZA VACCINATION			
		FOR CLINIC USE ONLY		School District ID	School Name
STUDENT INFORMATION (use black ink only)					
STUDENT FIRST NAME		MI	STUDENT LAST NAME		AGE GRADE
DATE OF BIRTH (MM/DD/YYYY) / /		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		SCHOOL	HOMEROOM TEACHER
RACE <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White				ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino	
STREET ADDRESS			CITY	STATE	ZIP
PARENT/GUARDIAN FIRST NAME		PARENT/GUARDIAN LAST NAME		PARENT/GUARDIAN CELL TELEPHONE () -	
PARENT/GUARDIAN EMAIL ADDRESS				PARENT/GUARDIAN HOME TELEPHONE () -	
INSURANCE INFORMATION (Please fill out completely)					
MEDICAID <input type="checkbox"/> Yes (Enter Medicaid Number) <input type="checkbox"/> No (Continue completing form)			SC MEDICAID NUMBER		
INSURANCE <input type="checkbox"/> Yes (Enter insurance information) <input type="checkbox"/> No (Skip to screening questions)			VACCINE <input type="checkbox"/> Yes COVERED <input type="checkbox"/> No		
PRIMARY INSURANCE			SUBSCRIBER/INSURED WORK TELEPHONE () -		
RELATIONSHIP TO THE SUBSCRIBER/INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT			MEMBER/INSURED ID		GROUP ID
SUBSCRIBER/INSURED FIRST NAME		SUBSCRIBER/INSURED LAST NAME		SUBSCRIBER/INSURED DOB (MM/DD/YYYY) / /	
				Subscriber Gender <input type="checkbox"/> M <input type="checkbox"/> F	
INFLUENZA VACCINATION SCREENING QUESTIONS					
The following questions will help us determine if there is any reason we should not give your child a seasonal influenza vaccination. If a question is not clear, please ask your healthcare provider to explain it. PLEASE ANSWER ALL QUESTIONS					
1. Has your child ever had a serious reaction to eggs OR a serious reaction to a previous flu vaccine that caused any of the following: wheezing, trouble breathing, hives and itching all over the body, swelling in the mouth or throat, very low blood pressure or shock?					NO YES <input type="checkbox"/> <input type="checkbox"/>
2. Has your child ever had Guillain-Barre Syndrome (a rare type of temporary severe muscle weakness and paralysis)?					NO YES <input type="checkbox"/> <input type="checkbox"/>
If you answered YES to any of the questions above, your child cannot receive the 2018-2019 seasonal influenza vaccine at school. Please contact your primary healthcare provider about the flu vaccine.					
If you answered NO to the above questions, please complete the following additional questions:					
3. If your child is under 9 years old, he/she may need 2 doses of flu vaccine. Please provide your child's date of birth <u>ONLY</u> if your child is under 9 years old.				DATE OF BIRTH / /	
4. If your child is under 9 years old, has your child received at least two doses of influenza vaccine prior to July 1, 2018?				NO YES UNSURE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
AUTHORIZATION AND CONSENT					
By signing below, I consent to the use and disclosure of my child's personal health information for public health purposes and program evaluation. DHEC's Privacy Notice can be found at the following link: http://www.scdhec.gov/library/ML-025046.pdf or a copy of the notice will be provided upon request.					
If applicable, by signing below, I request that payment of Medicaid benefits be made on my behalf to DHEC for any services provided to my child. I give DHEC permission to exchange my child's medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents, or other agents needed to determine benefits related to services provided. I agree to participate in treatment plans and to assignment of Medicaid benefits to DHEC for services rendered.					
Vaccine Authorization: I voluntarily request DHEC to provide seasonal influenza vaccine for my child named above, and consent for my child to receive the seasonal influenza vaccine at school, to be administered by DHEC staff. I have read the Vaccine Information Statement. Vaccine Information Statement can be found at the following link: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf . I have had an opportunity to ask questions about the vaccine. I understand the risks and benefits of the vaccine. I understand that the vaccine will be given as a shot. I have read and answered the questions above carefully and accurately, and I understand that incorrect information could cause serious risks to my child. In addition, I consent to my child receiving a second dose of the seasonal influenza vaccine, administered by DHEC, at a school clinic, if my child is less than 9 years old and a second dose is recommended by the U.S. Centers of Disease Control and Prevention (CDC). In case of occupational exposure, I consent to my child's blood testing if necessary for child and employee safety. I understand that immunization information about my child will be reported to SC Immunization Registry for public health purposes. I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.					
SIGNATURE OF PARENT OR LEGAL GUARDIAN				DATE / /	

VACCINATION DETAILS (Influenza V04.81) FOR CLINIC USE ONLY – BLACK INK ONLY

FIRST DOSE	VACCINE <input type="checkbox"/> IIV4	ELIGIBILITY <input type="checkbox"/> VFC > MEDICAID <input type="checkbox"/> VFC > AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> VFC > UNINSURED (NO INSURANCE) <input type="checkbox"/> STATE > UNDERINSURED <input type="checkbox"/> STATE > INSURED <input type="checkbox"/> ADULT > NO HEALTH INSURANCE <input type="checkbox"/> ADULT > UNDERINSURED <input type="checkbox"/> FFS > INSURED <input type="checkbox"/> FFS > MEDICAID <input type="checkbox"/> FFS > NO HEALTH INSURANCE <input type="checkbox"/> FFS > UNDERINSURED		
	MANUFACTURER <input type="checkbox"/> SANOFI PASTEUR <input type="checkbox"/> GLAXOSMITHKLINE	LOT NUMBER		SITE OF ADMINISTRATION <input type="checkbox"/> LD <input type="checkbox"/> RD <input type="checkbox"/> Other _____
	VIS DATE 08/07/2015			
	NURSE SIGNATURE		Nurse: I hereby attest by signature below that the patient (or guardian of patient) in question has been given the Influenza Vaccine Information Sheets and has given written consent for vaccination.	DATE / /
	PATIENT'S/STUDENT'S ASSIGNED CLASSROOM TEACHER SIGNATURE		Teacher: I hereby attest by signature below that the identity of the patient in question has been verified.	ECODE COUNTY CODE
			DATE / /	
<input type="checkbox"/> "What to Know After..." given to student <input type="checkbox"/> Unable to vaccinate due to _____ "Unable to Vaccinate" form given to student/school.				

SECOND DOSE	VACCINE <input type="checkbox"/> IIV4	ELIGIBILITY <input type="checkbox"/> VFC – MEDICAID <input type="checkbox"/> VFC – AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> VFC – UNINSURED (NO INSURANCE) <input type="checkbox"/> STATE – UNDERINSURED <input type="checkbox"/> STATE – INSURED <input type="checkbox"/> ADULT > NO HEALTH INSURANCE <input type="checkbox"/> ADULT > UNDERINSURED <input type="checkbox"/> FFS > INSURED <input type="checkbox"/> FFS > MEDICAID <input type="checkbox"/> FFS > NO HEALTH INSURANCE <input type="checkbox"/> FFS > UNDERINSURED		
	MANUFACTURER <input type="checkbox"/> SANOFI PASTEUR <input type="checkbox"/> GLAXOSMITHKLINE	LOT NUMBER		SITE OF ADMINISTRATION <input type="checkbox"/> LD <input type="checkbox"/> RD <input type="checkbox"/> Other _____
	VIS DATE 08/07/2015			
	NURSE SIGNATURE		Nurse: I hereby attest by signature below that the patient (or guardian of patient) in question has been given the Influenza Vaccine Information Sheets and has given written consent for vaccination.	DATE / /
	PATIENT'S/STUDENT'S ASSIGNED CLASSROOM TEACHER SIGNATURE		Teacher: I hereby attest by signature below that the identity of the patient in question has been verified.	ECODE COUNTY CODE
			DATE / /	
<input type="checkbox"/> "What to Know After..." given to student <input type="checkbox"/> Unable to vaccinate due to _____ "Unable to Vaccinate" form given to student/school				

NOTES

PRE-CLINIC SCREENING – FOR CLINIC USE ONLY	
FIRST DOSE ELIGIBILITY <input type="checkbox"/> VFC – MEDICAID <input type="checkbox"/> VFC – AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> VFC – UNINSURED (NO INSURANCE) <input type="checkbox"/> STATE – UNDERINSURED <input type="checkbox"/> STATE – INSURED <input type="checkbox"/> ADULT > NO HEALTH INSURANCE <input type="checkbox"/> ADULT > UNDERINSURED <input type="checkbox"/> FFS > INSURED <input type="checkbox"/> FFS > MEDICAID <input type="checkbox"/> FFS > NO HEALTH INSURANCE <input type="checkbox"/> FFS > UNDERINSURED	MCI NUMBER
SECOND DOSE NEEDED? <input type="checkbox"/> YES <input type="checkbox"/> NO SECOND DOSE ELIGIBILITY <input type="checkbox"/> VFC – MEDICAID <input type="checkbox"/> VFC – AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> VFC – UNINSURED (NO INSURANCE) <input type="checkbox"/> STATE – UNDERINSURED <input type="checkbox"/> STATE – INSURED	STUDENT'S NAME
	DATE OF BIRTH / /