

Flu Vaccine Consent Form

School Name: _____ Clinic Date: _____

PLEASE COMPLETE ALL OF THE INFORMATION BELOW - **Please print using ink** (Incomplete forms will not be accepted)

FIRST NAME of student:		MIDDLE INITIAL		LAST NAME of student:		SUFFIX (Jr., III, etc)	
Gender: Male Female	Birthdate: (mo,day,yr)			Age	Homeroom Teacher/Grade		
Address				Phone # () -	Mother's Maiden Name: (For registry)		
City	Zip Code	State		Race: (Circle one) African American / Black White Alaskan/ Native-American Asian Hawaiian / Pacific Islander Other Ethnicity: (circle one) Hispanic Non-Hispanic			
Email address:							

The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential.

Please fill out the following questions pertaining to your health insurance:

Medicaid <input type="checkbox"/>	No insurance <input type="checkbox"/>	Insurance Company:
Policy Holder's First Name:		Policy Holder's Last Name:
Member ID:		Policy Holder's Date of Birth: (mo,day,yr)

CHECK YES OR NO FOR **EACH** QUESTION

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Has your child ever had a life-threatening reaction(s) to the flu vaccine in the past?
<input type="checkbox"/>	<input type="checkbox"/>	2. Has your child ever had Guillain-Barre' syndrome?
<input type="checkbox"/>	<input type="checkbox"/>	3. Does your child have an allergy to eggs?
<input type="checkbox"/>	<input type="checkbox"/>	4. Does your child have a blood disorder such as hemophilia?
<input type="checkbox"/>	<input type="checkbox"/>	5. Will this be the first time your child has ever received a flu vaccination?



I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks, benefits and alternatives I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccines. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine's success. On behalf of my child and our heirs, I hereby release MaxVax LLC., affiliates, affiliated schools of nursing, their directors, employees and agents from any and all liability arising from any act or omission which arises during or in connection with a vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. I acknowledge that I am giving permission for MaxVax LLC. To file, adjudicate and appeal claims with my insurance providers on my behalf. Clinic dates when the vaccine will be administered can be obtained from the school. I understand that the health-related information on this form will be used for insurance billing purposes and the Personal Health Information contained herein will be protected per the law. I understand the purposes/benefits of Florida SHOTS, Florida's immunization registry and I request and voluntarily consent for the vaccine to be given and recorded in Florida SHOTS for the person listed above.

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Relationship to child

Date

VIS CDC IIV 08/06/2021
 LOT Number: _____
 RN # _____
 FLUCELVAX
 EXP Date: _____
 Date: _____
AREA FOR OFFICIAL ADMINISTRATION USE ONLY

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HEALTH HERO FLORIDA
 You Keep Them Learning.
 We Keep Them Healthy.