ATTACHMENT C

Healthy Schools

2016-2017 Seasonal FluMist Vaccine Consent Form
THIS FORM MUST BE RETURNED TO SCHOOL

PLEASE COMPLETE All THE INFORMATION BELOW (Unreadable and incomplete forms will not be accepted.)

Full, Legal Name of Student (*First Name Middle Initial. Last Name)* PLEASE PRINT	**Name of School**
Parent/Guardian Name (*First Name Middle Initial. Last Name)* **Relationship to Student**	**Homeroom Teacher / Grade**
Address **Email Address**	**Birth Date** (month / date / year) **Age** **Sex**
City **Zip Code**	**Home Phone #** **Cell Phone #**
Demographic Information: (Circle one) White American Indian/ Native Alaskan Black Asian Hispanic Other	

Insurance ☐ **Medicaid** ☐	**Please fill out the following questions pertaining to your child's Health Insurance:**
Insurance Company:	**Member ID:**
Policy Holder's Name:	**Policy Holder's Date of Birth:**
The current health care laws require us to bill your insurance company for the vaccine. You will not be billed, and there will be no co-pay or deductible due. The service is offered at no cost to you! As always, answers are confidential.	☐ **MY CHILD DOES NOT HAVE HEALTH INS** ☐ **PLEASE CONTACT ME ABOUT COVERAGE**

QUESTIONS: CHECK YES OR NO FOR **EACH** QUESTION

Yes ☐ No ☐

1.) Do any of the following apply to your child? ***(If you answer YES, your child cannot receive FluMist, please contact your child's doctor or local Health Department to receive the Flu Vaccine)***

- **Allergy to chicken eggs or egg products**
- **Life threatening reaction(s) to flu vaccine in the past**
- **Has had Guillain-Barre syndrome (very rare)**
- **Currently receiving aspirin or aspirin-containing therapy**
- **Currently has active asthma (regularly taking asthma meds)**
- **Is Pregnant or Nursing/Breastfeeding**
- **Has HIV/AIDS or cancer or has received an organ transplant**
- **Has long-term health problems with weakened immune system, heart disease, lung disease (e.g. cystic fibrosis), liver disease, kidney disease, or metabolic disorders (e.g. diabetes) or blood disorders (e.g. sickle disease or thalassemia)**
- **Has other severe chronic health conditions**

Yes ☐ No ☐

1.) Will your child have close contact with a person with a severely weakened immune system? (e.g. protective sterile hospital environment for bone marrow transplant)

Yes ☐ No ☐

1.) Within the last 30 days, has/will your child receive one of the following vaccines: MMR, MMRV, and/or Chicken pox vaccine (VZV)? If YES please list the date received _____

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL HEALTHY SCHOOLS AT 1-800-566-0596 TO SPEAK TO A HEALTHY SCHOOLS NURSE.

I have received, read, and understand the CDC Vaccine Information Statement for the live attenuated intranasal flu vaccine (FluMist). I have read these documents and understand the risk and benefits of the FluMist vaccine. I give permission to Healthy Schools and their administrators to give my child the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing and storage according to Florida Department of Health policies, to assure optimal healthcare for my child. . I hereby release Healthy Schools from any and all liability associated with the administration and potential side effects of the vaccine.

☐ **YES, I Want To Help Protect My Family And Community From Flu By Allowing My Child To Receive FluMist!**

☐ NO, I do not want my child to receive the Flu-Fighting FluMist Vaccine at school because_____(optional)

_____ _____ _____

Printed Name of Parent/Guardian **Signature of Parent/Guardian** **Date**

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

VIS CDC LAIV_____2015 FluMist 0.2mL Intranasal **LOT Number:** **EXP Date:** RN #_____ Date:_____	VIS CDC LAIV_____2015 FluMist 0.2 mL Intranasal **LOT Number:** **EXP Date:** RN # _____ Date: _____