Established 1915 BROWARD County Public Schools

2018-2019 Seasonal Flu Shot (IIV*) Vaccine Consent Form

EXHIBIT 1 Healthy Schools

Sign your child up for a no-cost vaccination offered during school hours.

PLEASE PRINT

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

Please fill out the following questions pertaining to your child's Health Insurance:

Circle one: Insurance Medicaid (example: AmeriGroup, Wellcare, Integral, Prestige, Humana, Sunshine, BetterHealth)

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, deductible or out-of-pocket expense for the services provided.	☐ MY CHILD DOES NOT HAVE HEALTH INSURANCE

QUESTIONS: Check YES or NO for each question.

☐ Yes ☐ No	Is your child 4 years or older?
☐ Yes ☐ No	Do any of the following apply to your child? (If you answer YES, your child cannot receive a Flu Vaccine at school, please contact your child's doctor) • Allergy to chicken eggs or egg products • Life threatening reaction(s) to flu vaccine in the past • Allergy to Latex • Has had Guillain-Barre syndrome (very rare)
☐ Yes ☐ No	Do any of the below apply to your child? 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)

If you have any health questions, please contact your child's pediatrician or call Healthy Schools LLC at 1-800-566-0596 to speak to a nurse.

Disclosure of SBBC Student Information:
I hereby give consent for SBBC to provide all of the information on this consent form (including medical information, demographics and contact information) to Healthy Schools for licensed healthcare providers to administer vaccination services to my child.

I have received, read, and understand the CDC Vaccine Information Statement for the Inactivated Influenza Vaccine (IIV). I have read these documents and understand the risk and benefits of the IIV 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. I understand that by virtue of the services provided by Healthy Schools, my child and Healthy Schools will be creating a provider-patient relationship. By providing my cell phone I understand that I may be contacted at that number, including text messages, with information regarding Healthy School's services.

☐ **YES, I want to help protect my family and community from flu by allowing my child to receive a flu shot.**

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

AREA FOR OFFICIAL USE ONLY

VIS CDC IIV	IIVt0.5L IM Injection		VIS CDC IIV	IIVt0.5L IM Injection	
LOT Number:		EXP Date:	LOT Number:		EXP Date:
RN #	Date	RUA or LUA (Circle One)	RN #	Date	RUA or LUA (Circle One)

*Inactivated Influenza Vaccine