Taylor County
Public Health
712-523-3405

FLU SHOT
2017 SCREENING & CONSENT FOR SCHOOLS

Lenox and Bedford

Student's last name _____First name _____Middle name_____

Date of Birth: _____ Age:_____ Circle → Male or Female School/Building_____Grade/Room _____

Address: _____City:_____,IA Zip_____

Name of Parent or Guardian_____ Mother's Maiden name_____

Daytime phone: _____ Child's doctor/name of clinic:_____Phone:_____

Circle one choice below that pertains to this child:

- Is enrolled in Medicaid (Title 19) **AND** Circle one: Amerihealth Caritas or United Healthcare or Amerigroup
- Does not have any health insurance (no charge)
- Has health insurance that DOES NOT pay for flu vaccines (no charge)
- Is American Indian or Alaskan Native or (no charge) OR:
- My child has insurance that pays for vaccine. **Circle one:** Wellmark Blue Cross Blue Sheild or *hawk*-I or Medicaid

Insurance ID # _____ Group # _____Policy holder's name _____

Policy holder's date of birth_____ **staple a copy of your insurance card to this consent form.**

For Flu shot, continue to answer the questions below by circling NO or explain if YES.

1. Does the child have allergies to medications, food, a vaccine component or latex? (eggs, bovine protein, gelatin, gentamicin, polymixin, phenol or thimerosal) **No if Yes, explain**_____
2. Has the child, a sibling or a parent had a seizure; has the child had brain or other nervous system problems? **No, if yes explain**_____
3. Has your child ever had Guillain-Barrre" Syndrome? **NO** *If **YES, explain*** _____
4. Allergies:_____
5. Current medications:_____
6. Has your child ever had a serious reaction to a vaccine in the past? **NO** If **YES explain**_____
7. Is this child pregnant or is there a chance she could become pregnant in the next month? **No if yes explain**_____

I agree to the following:

1. I have read or have had read to me, the Vaccine Information Sheet dated 8/7/15 regarding the Influenza vaccine.
2. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the flu vaccine.
3. To have the child's health insurance billed. If insurance does not pay for the whole amount, I agree to pay the difference.
4. I authorize the release of any medical or other information necessary to process the claim. I also request payment of government benefits to the party who accepts assignment.
5. I understand this vaccine will be entered into the State's immunization database called "IRIS".
6. I accept responsibility for seeking medical attention for any problems with this vaccine.
7. *Children younger than 9 may need a second dose in one month if this is their first dose. Please plan to get the second dose at your medical provider office, pharmacy or Public Health. We will not be returning to the school for second doses or for absences on the day that we come to the school.*
8. I fully discharge, their offices, directors and employees from any liability for illness or damage which may result there from.

I give permission for my child to receive the Influenza vaccine (Flu shot)

Signature of parent/guardian:_____ Date_____

---For office use below---

Is the child sick today? **NO,** If **YES, explain**_____

Has the child had any immunizations in the last 4 weeks **No, if Yes explain**_____

Date	Circle Source	Product name	Dosage 0.5cc 0.25cc	Provider Signature
	VFC or **Private**	**Lot #**	**Injection Site/route** **Left Right Deltoid** **IM SQ**	

Return this form to school by September 1, 2017

DATE in IRIS:_____ INITIALS_____