MPP Reviewer

School Nurse

Howard County Public Schools Consent Form for SY 2018-19 INJECTABLE Flu Clinic

Fill out this section

Please Print Clearly in Ink

Student's LAST Name	Student's FIRST Name	M.I.	Student's Birthdate / /	Age	Sex F M	Grade
Parent/Guardian LAST Name	Parent/Guardian FIRST Name	M.I.	Cell/Daytime Phone			
Address			Email Address			
City	ZIP Code		School Name		Teacher/Homeroom	

Fill out this section

HEALTH INSURANCE INFORMATION – PLEASE FILL OUT COMPLETELY AND ACCURATELY

Please copy this information from YOUR INSURANCE CARD. We will bill your insurance. You will NOT be charged a co-pay or a deductible.

Type of Insurance: ☐ **Private Insurance or Medical Assistance** ☐ **My child does not have health insurance** (Your child will not be turned away because of no insurance)

Insurance Company Name	Member ID Number (write in boxes below)
	Group Number

FOR PRIVATE INSURANCE ONLY.

Policy Holder's/Insured Adult's Name | **Relationship to Student** | **Insured Adult's Birthdate** | **Any Other # from Insurance Card**

Answer these

1. Do any of the following apply to your child? ***(If you answer YES to any question, your child might not be vaccinated.)***

Yes	No		Yes	No	
☐	☐	Has had a serious reaction to a vaccine in the past?	☐	☐	Has had Guillain-Barre syndrome?
☐	☐	Has a serious allergy to eggs?	☐	☐	Has an allergy to a component in flu vaccine? If "yes", explain:_____

If your child is under 9 years old and has not had a flu vaccination before, she/he may need a second flu vaccination this year. Please check with your health care provider to see if your child needs a second "dose" of the vaccine.

If you have any questions about flu vaccine, please contact your child's doctor or the health department or go to www.flu.gov.

CONSENT FOR VACCINATION(S) – YOU MUST SIGN HERE FOR YOUR CHILD TO BE VACCINATED

By signing this form, I give permission for my child to be vaccinated, my insurance company to be billed, and vaccine entered into ImmuNet, Maryland's immunization registry. Further, I agree that:

(1) The information above is correct; (2) I have read the current Vaccine Information Statement or someone has read it to me;
(3) I understand the risks and benefits of getting the vaccine I have consented for my child to receive; and
(4) Any questions I had about the vaccine(s) have been answered.

Signature of Parent/Legal Guardian_____ **Date:** ____/____/____

FOR OFFICE USE ONLY

Date of Administration / VIS Given	Vaccine	Vaccine Manufacturer	Lot Number	PRINT Name of Vaccine Administrator