For Office Use	
Private	VFC

2018 Influenza Vaccine School Consent Form

Polk County Health Department

STUDENT'S NAME (Last)	(First)		(M.I.)	**GRADE**	**TEACHER/ADVISOR**	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)		(M.I.)	**STUDENT'S BIRTH DATE (m/d/y)** / /	**AGE**	**GENDER** M / F
ADDRESS				**PARENT/GUARDIAN DAYTIME PHONE NUMBER:**		
CITY	**STATE**	**ZIP**		**SCHOOL**		

Please answer the following questions by circling "YES" or "NO". We need this health information to determine if your child should receive this vaccine. Only the injectable vaccine (the shot) is available.

1. Does your child have a serious allergy to eggs?	YES	NO
2. Does your child have any other serious allergies? Please list:	YES	NO
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	YES	NO
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO

Please circle your child's insurance coverage and "YES" or "NO" for insurance billing consent. Fill in the requested insurance numbers or attach a copy of the insurance card.

1. Please **circle** the best description of your child's health insurance coverage. Your child will receive vaccine regardless of insurance coverage.

Health Insurance, vaccines covered **Health Insurance, vaccines not covered** **Badger Care** **No health insurance**

2. I consent to allow the Polk County Health Department to bill my insurance company for the administration of influenza vaccine. **Please complete this section or attach a copy of your child's insurance card.** YES NO

Name of Health Insurance Plan/Company:

____

Group # ______________________________ Child's ID#____________________________________

Subscriber's Name (print) ____

Parent consent to vaccinate and share records.

Only sign **this form below** ***if you want your child vaccinated.***

I have read the influenza vaccine "Vaccine Information Statement" provided to me and published on 8/7/2015 and I understand the risks and benefits. By signing this consent form I give permission to the Polk County Health Department to administer influenza vaccine to the child listed above.

Parent or Guardian Signature: ____ Date: ________________

Do we have your permission to share your child's immunization record with the WIR? Yes ☐ No ☐

Date Dose Administered	Route	Site	Manufacturer and Lot Number	Name and Title of Vaccine Administrator
	IM ☐	☐ LD ☐ RD		