Tennessee Department of Health School Located Influenza Vaccination Project
Student Consent Form and Influenza Immunization Documentation Form

If you want a Flu Vaccination given to your child, COMPLETE THE INFORMATION ON THE FRONT AND BACK OF THIS FORM AND SIGN.

PLEASE PRINT

School: _____ ***Home Room Teacher:*** _____ ***Grade :*** _____

Student: *Last Name* _____ *First Name:* _____ *MI :* _____

SEX: ☐ M ☐ F *DOB:* ____/____/____ *Current Age:* _____ *Child's SSN:* _____

RACE: ☐ *Asian* ☐ *Black* ☐ *Native American* ☐ *Pacific Islander* ☐ *White* ☐ *Other* ***ETHNICITY****: Hispanic* ☐ ***Y*** ☐ ***N***

Address: _____ ***City:*** _____ ***State:*** _____ ***Zip:*** _____

Parent/Guardian: Last Name: _____ ***First Name:*** _____ ***MI:*** _____

Parent/Guardian Home Phone: ( ) _____ ***Cell Phone:*** ( ) _____

ALL QUESTIONS MUST BE COMPLETED BY CHECKING YES OR NO IN ORDER FOR THE STUDENT TO RECEIVE A FLU VACCINE The Nurse giving the vaccination will review the information on vaccination day.	YES	NO
1. Has your child ever received a flu vaccine?		
2. Has your child received at least 2 seasonal Influenza (flu) vaccine doses in their lifetime? If unsure, mark No.		
3. Has your child ever had a severe (life threatening) allergic reaction to the flu vaccine requiring urgent medical attention?		
4. Does your child have severe (life threatening) allergy to eggs (requiring urgent medical attention? **If yes, describe:**		
5. Is your child allergic to vaccine components such as gentamicin, arginine, gelatin, MSG? **If yes, describe reaction:**		
6. Has your child ever had Guillain-Barre´ syndrome?		

Request for Administration of Influenza Vaccine for the above named recipient: I will receive information about the vaccine and special precautions on the Vaccine Information Sheet prior to my child receiving the vaccine and on the day of vaccination. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to the person above of whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release Tennessee Department of Health, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

I understand that this document will be given to and retained by the public health department. I give permission for my child's school to retain a copy if needed.
I acknowledge that I have been given the Department of Health's Notice of Privacy Practices.
I give consent to bill TennCare and/or private insurance for the service provided.

This Consent Form is valid for administration of influenza vaccinations for six (6) months. It may be used to administer a second dose of influenza vaccine, if needed. I understand that I should report any changes of the above information to the health department prior to vaccination.

_____ _____
Parent/Guardian Signature **Date**

PLEASE COMPLETE THE INFORMATION ON THE BACK OF THIS FORM

PARENTS: Please answer all questions below to provide necessary billing information and to determine if your child