Parental Consent Form

HEALTH HERO
You Keep Them Smart We Keep Them Healthy
by WORKS!

Clinic Date: _____ **Due Date:** _____

Make you child a Health Hero

Shelby County Schools!

Questions please call or email us at lacy@teachflualesson.info, visit our FAQ page at www.HealthHeroUSA.com or the CDC at www.cdc.gov/flu for the most updated Vaccine Information Statement. PEEHIP members and dependents are required to participate in the ADPH Wellness clinic for any onsite vaccinations.

For the health of all of our students, faculty, and your family, we encourage you to obtain a flu vaccination for your student through our voluntary clinic, your local healthcare provider or pediatrician. We recommend immunizing using a **pain-free FluMist® Quadrivalent vaccine.** If your child's **Medical** condition requires administration via a traditional shot method please call us at (205) 609-0268 to receive a shot consent form. Any concerns or questions please call HNH Immunizations or speak with your school's health representative.

Student Info: Incomplete or unreadable forms - student will **not** be vaccinated. Print neatly in INK - One letter/number per box

First Name		Middle Initial		Last Name	
Child Birth Date		AGE		Gender (M / F)		Grade	
School Name		Home Room Teacher	
Student Race Please Circle	African American / Black	Alaskan / Native American	Asian	Hawaiian / Pacific Islander	Hispanic	White	Multiple	Other	Decline

Authorizing Parent or Guardian: Incomplete or unreadable forms-Student will **not** be vaccinated. One letter/number per box

First Name		Last Name		Circle One	Parent	Guardian
Street Address		City		Zip	
Emergency Contact #		Child's Medical Provider & Phone #	
Email Address (for clinic info only)	

Insurance information: IMPORTANT please read carefully.
This clinic is voluntary. There are no out of pocket costs therefore we must have proper insurance information to bill Health Insurance Providers who pay for this vaccination. If proper information is not provided the student will **NOT** be vaccinated. If in doubt we always recommend stapling a copy of the front and back side of your medical insurance card to this parent consent form and return to the school. **ONLY one of the following four insurance information sections must be filled out.**

1 If student has **NO** medical insurance coverage check this box. ☐ Do not check this box if student is covered under Medicaid.

2 If student is underinsured because flu vaccine is not covered or Insurance Co. caps vaccine coverage check this box. ☐

3 If student has medical insurance through a Medicaid program—**not** insured through Parent or Guardian, i.e. FAMIS, CHIP, etc.

Medicaid Insurance		Medicaid Insurance Number	

4 If student has Private medical insurance or TRICARE through a Parent or Guardian.

Insurance Co. Name (not Medicare)		Employer of Insured Parent or Guardian	
Insured ADULT Full Name		Insured ADULT Birth Date	
Member ID or Policy #		Group #	

HNH Immunizations, Inc., 326 Prairie St. North, Union Springs, AL 36089
(205) 609-0268

Turn over & fill out backside ➡

REQUIRED Health Related Questions— All questions must be answered for your child to be immunized

1	Has this child been diagnosed with Asthma? If yes, date of last treatment: _____ Has the inhaler been used one or more times in the last month?	YES YES	NO NO
2	Has this child ever had a severe or life threatening allergic reaction to the flu vaccine?	YES	NO
3	Does this child have any of the following: Diabetes or other metabolic disorders Heart disease or disorders Kidney disease or disorders Blood disease or disorders	 YES YES YES YES	 NO NO NO NO
4	Is this child allergic to vaccine components such as: eggs, gentamicin sulfate, or MSG?	YES	NO
5	Is this child pregnant or nursing?	YES	NO
6	Has this child ever had Guillain-Barre syndrome?	YES	NO
7	Is this child on long term aspirin therapy?	YES	NO
8	Does this child live with or expect to have close contact with a person whose immune system is severely compromised and must be in a protective isolation environment?	YES	NO
9	Does this child take medications that lower the body's resistance to infection?	YES	NO
10	Has this child received a MMR or Varicella vaccine in the last 30 days?	YES	NO

PLEASE ANSWER EACH QUESTION

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The medical history will be reviewed by licensed medical professionals. Certain conditions will require your child to be immunized by your regular health care provider. Your child's safety is our primary concern.

Additional questions

A	Is this the first time this child will be vaccinated for the flu?	YES	NO
B	Was this child flu vaccinated for the first time last year? If yes, how many doses?	YES	NO
C	Has this child received any other vaccinations in the past 4 weeks? If yes, list vaccination(s)?	YES	NO

STUDENT NAME: (please print) _____

I am aware that the receiver of this vaccine is currently not pregnant and should not become pregnant within four weeks of receiving this vaccine. I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine's success. I hereby release the school system, HNH Immunizations, Inc. & subsidiaries, the Family Health Clinic of Union Springs, affiliated schools of nursing, their directors and employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. Clinic dates can be obtained from the school. I understand that the health related information on this form will be used for insurance billing purposes and your privacy will be protected.

MUST SIGN & DATE

_____ Parent or Guardian Signature

_____ Date

For Administrative Use Only

Clinic Loc:	Date of Clinic:
Vaccine Lot & Expiration Date:	
RPh:	RN:
VIS CDC LAIV 8/19/2014	0.2mL Intranasal
Vaccine: FluMist Quadrivalent	Manufacturer: MedImmune

Cash	Check
DB:	
Filed:	
PDF:	
Other:	