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

INJECTION ☐ **MIST** ☐

For the health of all of our students, faculty, and your family, we encourage you to obtain a flu vaccination for your child with their local healthcare provider or pediatrician.

Parker County Hospital District Outreach Program will be offering the Quadrivalent Flu injection and FLUMIST for students with no deductibles or out of pocket expenses. **Private insurance companies will be billed.** Students with no insurance will be provided their flu vaccine at no cost.

The "Say Shoo To The Flu" Clinic is voluntary. If you wish to participate in this convenient clinic to help keep your child and our schools healthy, please **complete both sides** of this form in full.

****** Please check if your child will be receiving the injection or mist. If this is not checked your child will receive the injection. ******

STUDENT INFORMATION

First Name:	Middle Initial:	Last Name:	
Date of Birth: (MM / DD / YY)	Male or Female	Name of School:	Grade:
Student Race: **Please circle** White African American Hispanic American Indian Alaskan Native Other			

Authorizing Parent or Guardian Information

First Name:	Last Name:	Relationship:
Address:	City:	Zip:
Cell or Emergency Contact Number:	Mother (of minor) Maiden name:	

Required Insurance Information

BCBS	Cigna	Aetna	Tricare	United	Medicaid	Uninsured	Underinsured:* insurance coverage but does not cover vaccine * Insurance only covers select vaccines * Insurance caps vaccine coverage

Card Holder Name:	Card Holder DOB: (MM / DD / YY)	Member ID # (Include prefix ex. ZGP,W) Group #

PLEASE COMPLETE MEDICAL HISTORY QUESTIONS ON THE REVERSE SIDE. Vaccinations cannot be given without parent's or guardian's signature.

Parker County Hospital District
1130 Pecan Street, Weatherford, TX 76086
817-458-3254

Parker County Hospital District

Vaccination & Health Related Questions

1. Is this the first time this patient will be vaccinated for the flu?	YES	NO
2. Does this patient have Asthma? If yes , date of last treatment?_____	YES	NO
3. Has this patient ever had a severe or life threatening allergic reaction to the flu vaccine?	YES	NO
4. Does this patient have any of the following: If **YES** please circle which one applies:	YES	NO
Blood disease / Diabetes / Heart Disease / Kidney disease / Lung disease / Liver disease		
5. Is this patient allergic to vaccine components such as: eggs, gentamicin sulfate, gelatin, or MSG?	YES	NO
6. Is this patient pregnant or nursing?	YES	NO
7. Has this patient ever had Guillain–Barre syndrome?	YES	NO
8. Is this patient receiving aspirin therapy or aspirin-containing therapy?	YES	NO
9. Does this patient take medications that lower the body's resistance to infection? Ex: cortisone, prednisone, other steroids	YES	NO
10. Does this patient 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? (e.g. isolation room of a bone marrow transplant unit)	YES	NO
11. Has this patient received any other vaccinations in the past 4 weeks?	YES	NO
If **YES** please list the names of the vaccines._____		

Authorization for the Administration of the Influenza Vaccine

I am providing this consent form to Parker County Hospital District in order that I may be given the influenza vaccination. I have read and understand the information I have received concerning the possible benefits and side effects of the influenza vaccinations. I hereby acknowledge that based on the information presented to me, I am eligible to receive the influenza vaccine on this date. I am feeling well today and I have not recently had fever. I understand that no assurance can be given that the influenza vaccination will give me immunity from contracting any strain of influenza. I hereby acknowledge that I have received a copy of the Vaccine Information Sheet on the 2015-2016 Influenza Vaccine. I release Parker County Hospital District, its employees, representatives and agents from any liability for giving me the influenza vaccination. I accept responsibility for seeking medical attention for any problems associated with my receiving the vaccine. I am also aware that the receiver of this vaccine is currently not pregnant and should not become pregnant within 4 weeks of receiving FluMist. I have had the opportunity to have all my questions answered. I understand that this consent is valid for 6 months and I will make PCHD/school aware of any changes prior to being vaccinated.

_____ _____

Signature of Patient/ Parent or Guardian Date

Staff Signature_____ Date_____

For Administrative Use Only

Clinic Location: Date:	Cash Check
Vaccine Lot & Expiration Date:	Data Entered and Filed:
Administered by:	By: Date:
VIS CDC IIV 2015/2016 Location: RA LA 0.5ml	Other:
VIS CDC LAIV 2015/ 2016 0.2ml Intranasal	