PARENT CONSENT FOR SEASONAL INFLUENZA VACCINATION

dhec

FOR CLINIC USE ONLY	School District ID 11601004	School Name HARTSVILLE MIDDLE SCHOOL

STUDENT INFORMATION (use black ink only)

STUDENT FIRST NAME	MI	STUDENT LAST NAME	AGE	GRADE

DATE OF BIRTH (MM/DD/YYYY) / /	GENDER ☐ MALE ☐ FEMALE	SCHOOL Hartsville Middle School	HOMEROOM TEACHER

RACE ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White

ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino

STREET ADDRESS	CITY	STATE	ZIP

PARENT/GUARDIAN FIRST NAME	PARENT/GUARDIAN LAST NAME	PARENT/GUARDIAN CELL TELEPHONE ( ) -

PARENT/GUARDIAN EMAIL ADDRESS	PARENT/GUARDIAN HOME TELEPHONE ( ) -

INSURANCE INFORMATION (Please fill out completely)

MEDICAID ☐ Yes (Enter Medicaid Number) ☐ No (Continue completing form) — SC MEDICAID NUMBER

INSURANCE ☐ Yes (Enter insurance information) ☐ No (Skip to screening questions)) — VACCINE COVERED ☐ Yes ☐ No

PRIMARY INSURANCE	SUBSCRIBER/INSURED WORK TELEPHONE ( ) -

RELATIONSHIP TO THE SUBSCRIBER/INSURED ☐ SELF ☐ SPOUSE ☐ DEPENDENT	MEMBER/INSURED ID	GROUP ID

SUBSCRIBER/INSURED FIRST NAME	SUBSCRIBER/INSURED LAST NAME	SUBSCRIBER/INSURED DOB (MM/DD/YYYY) / /	Subscriber Gender ☐ M ☐ F

INFLUENZA VACCINATION SCREENING QUESTIONS

The following questions will help us determine if there is any reason we should not give your child a seasonal influenza vaccination. If a question is not clear, please ask your healthcare provider to explain it. PLEASE ANSWER ALL QUESTIONS

1.	Has your child ever had a serious reaction to eggs OR a serious reaction to a previous flu vaccine that caused any of the following: wheezing, trouble breathing, hives and itching all over the body, swelling in the mouth or throat, very low blood pressure or shock?	NO ☐ YES ☐
2.	Has your child ever had Guillain-Barre Syndrome (a rare type of temporary severe muscle weakness and paralysis)?	NO ☐ YES ☐

If you answered YES to any of the questions above, your child cannot receive the 2018-2019 seasonal influenza vaccine at school. Please contact your primary healthcare provider about the flu vaccine.

If you answered NO to the above questions, please complete the following additional questions:

3.	**If your child is under 9 years old**, he/she may need 2 doses of flu vaccine. Please provide your child's date of birth ONLY if your child is under 9 years old.	DATE OF BIRTH / /
4.	**If your child is under 9 years old**, has your child received at least two doses of influenza vaccine prior to July 1, 2018?	NO ☐ YES ☐ UNSURE ☐

AUTHORIZATION AND CONSENT

By signing below, I consent to the use and disclosure of my child's personal health information for public health purposes and program evaluation. DHEC's Privacy Notice can be found at the following link: http://www.scdhec.gov/library/ML-025046.pdf or a copy of the notice will be provided upon request.

If applicable, by signing below, I request that payment of Medicaid benefits be made on my behalf to DHEC for any services provided to my child. I give DHEC permission to exchange my child's medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents, or other agents needed to determine benefits related to services provided. I agree to participate in treatment plans and to assignment of Medicaid benefits to DHEC for services rendered.

Vaccine Authorization: I voluntarily request DHEC to provide seasonal influenza vaccine for my child named above, and consent for my child to receive the seasonal influenza vaccine at school, to be administered by DHEC staff. I have read the Vaccine Information Statement. Vaccine Information Statement can be found at the following link: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf. I have had an opportunity to ask questions about the vaccine. I understand the risks and benefits of the vaccine. I understand that the vaccine will be given as a shot. I have read and answered the questions above carefully and accurately, and I understand that incorrect information could cause serious risks to my child. In addition, I consent to my child receiving a second dose of the seasonal influenza vaccine, administered by DHEC, at a school clinic, if my child is less than 9 years old and a second dose is recommended by the U.S. Centers of Disease Control and Prevention (CDC). In case of occupational exposure, I consent to my child's blood testing if necessary for child and employee safety. I understand that immunization information about my child will be reported to SC Immunization Registry for public health purposes. I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.

SIGNATURE OF PARENT OR LEGAL GUARDIAN	DATE / /

VACCINATION DETAILS (Influenza V04.81) FOR CLINIC USE ONLY – BLACK INK ONLY

FIRST DOSE

VACCINE
☐ IIV4

ELIGIBILITY
☐ VFC > MEDICAID ☐ VFC > AMERICAN INDIAN/ALASKA NATIVE ☐ VFC > UNINSURED (NO INSURANCE)
☐ STATE > UNDERINSURED ☐ STATE > INSURED ☐ ADULT > NO HEALTH INSURANCE ☐ ADULT > UNDERINSURED
☐ FFS > INSURED ☐ FFS > MEDICAID ☐ FFS > NO HEALTH INSURANCE ☐ FFS > UNDERINSURED

MANUFACTURER
☐ SANOFI PASTEUR
☐ GLAXOSMITHKLINE
VIS DATE 08/07/2015

LOT NUMBER

SITE OF ADMINISTRATION
☐ LD
☐ RD
☐ Other_____

NURSE SIGNATURE

Nurse: I hereby attest by signature below that the patient (or guardian of patient) in question has been given the Influenza Vaccine Information Sheets and has given written consent for vaccination.

DATE / /

ECODE

COUNTY CODE

PATIENT'S/STUDENT'S ASSIGNED CLASSROOM TEACHER SIGNATURE

Teacher: I hereby attest by signature below that the identity of the patient in question has been verified.

DATE / /

☐ "What to Know After…" given to student ☐ Unable to vaccinate due to _____ "Unable to Vaccinate" form given to student/school.

SECOND DOSE

VACCINE
☐ IIV4

ELIGIBILITY
☐ VFC – MEDICAID ☐ VFC – AMERICAN INDIAN/ALASKA NATIVE ☐ VFC – UNINSURED (NO INSURANCE)
☐ STATE – UNDERINSURED ☐ STATE – INSURED ☐ ADULT > NO HEALTH INSURANCE ☐ ADULT > UNDERINSURED
☐ FFS > INSURED ☐ FFS > MEDICAID ☐ FFS > NO HEALTH INSURANCE ☐ FFS > UNDERINSURED

MANUFACTURER
☐ SANOFI PASTEUR
☐ GLAXOSMITHKLINE
VIS DATE 08/07/2015

LOT NUMBER

SITE OF ADMINISTRATION
☐ LD
☐ RD
☐ Other_____

NURSE SIGNATURE

Nurse: I hereby attest by signature below that the patient (or guardian of patient) in question has been given the Influenza Vaccine Information Sheets and has given written consent for vaccination.

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COUNTY CODE

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Teacher: I hereby attest by signature below that the identity of the patient in question has been verified.

DATE / /

☐ "What to Know After…" given to student ☐ Unable to vaccinate due to _____ "Unable to Vaccinate" form given to student/school

NOTES

PRE-CLINIC SCREENING – FOR CLINIC USE ONLY

FIRST DOSE ELIGIBILITY
☐ VFC – MEDICAID ☐ VFC – AMERICAN INDIAN/ALASKA NATIVE
☐ VFC – UNINSURED (NO INSURANCE)
☐ STATE – UNDERINSURED ☐ STATE – INSURED
☐ ADULT > NO HEALTH INSURANCE ☐ ADULT > UNDERINSURED
☐ FFS > INSURED ☐ FFS > MEDICAID
☐ FFS > NO HEALTH INSURANCE ☐ FFS > UNDERINSURED

SECOND DOSE NEEDED? ☐ YES ☐ NO
SECOND DOSE ELIGIBILITY
☐ VFC – MEDICAID ☐ VFC – AMERICAN INDIAN/ALASKA NATIVE
☐ VFC – UNINSURED (NO INSURANCE)
☐ STATE – UNDERINSURED ☐ STATE – INSURED

MCI NUMBER

STUDENT'S NAME

DATE OF BIRTH / /

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL