

Flu Vaccine Consent Form

School Name: San Antonio Elem. Clinic Date: 10/6/23

PLEASE COMPLETE ALL OF THE INFORMATION BELOW - Please print using ink (Incomplete forms will not be accepted)

FIRST NAME of student:				MIDDLE INITIAL				LAST NAME of student:				SUFFIX (Jr., III, etc)							
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Birthdate: (mo,day,yr)		M	M	D	D	Y	Y	Y	Y	Age		Grade		Homeroom Teacher			
Address								Phone #				Mother's Maiden Name: (For registry)							
City				State				Zip Code				Student Race <input type="checkbox"/> African American / Black <input type="checkbox"/> White <input type="checkbox"/> Asian		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Hawaiian / Pacific Islander <input type="checkbox"/> Alaskan/ Native-American <input type="checkbox"/> Other <input type="checkbox"/> Non-Hispanic					
Email address:																			

The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential.

Please fill out the following questions pertaining to your health insurance:

<input type="checkbox"/> Medicaid Medicaid Provider:				<input type="checkbox"/> No insurance				My child has Commercial Insurance. Please Provide Insurance Company Name. Not VFC Eligible Insurance Name:							
Policy Holder's First Name:								Policy Holder's Last Name:							
Member ID:				Policy Holder's Date of Birth: (mo,day,yr)				M	M	D	D	Y	Y	Y	Y

CHECK YES OR NO FOR EACH QUESTION

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Has your child ever had a life-threatening reaction(s) to the flu vaccine in the past?
<input type="checkbox"/>	<input type="checkbox"/>	2. Has your child ever had Guillain-Barre' syndrome?
<input type="checkbox"/>	<input type="checkbox"/>	3. Does your child have an allergy to eggs?
<input type="checkbox"/>	<input type="checkbox"/>	4. Does your child have a blood disorder such as hemophilia?
<input type="checkbox"/>	<input type="checkbox"/>	5. Will this be the first time your child has ever received a flu vaccination?



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 MaxVax LLC., affiliates, affiliated schools of nursing, their directors, employees and agents 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. I acknowledge that I am giving permission for MaxVax LLC. to adjudicate and appeal claims with my insurance providers on my behalf. 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 Personal Health Information contained herein will be protected. I request and voluntarily consent for the vaccine to be given and recorded in Florida SHOTS for the person listed above.

Printed Name of Parent/Guardian with authority to authorize vaccinations _____ Signature of Parent/Guardian with authority to authorize vaccinations _____ Relationship to child _____ Date _____

VIS CDC IIV 08/06/2021 LOT Number: RN #		INFLUENZA EXP Date: Date:		Health Hero 320 1st St N #103 Jacksonville Beach, FL 32250 help@beahealthhero.com www.beahealthhero.com			
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