(Katy Trail will be coming to all Sedalia 200 schools between the dates of 10/7/2024 through 10/10/2024 to administer the influenza vaccination to those who consent ONLY! A consent form is required and must be returned prior to 10/4/24.)

# IMMUNIZATION CONSENT FORM

Before your child may receive vaccinations from Katy Trail Community Health, you must read the vaccine information sheets (VIS) for all vaccines being administered and answer the below questions. Vaccinations will only be administered to children and adolescents 0-19 years old who are healthy and not pregnant. Katy Trail Community Health will keep this questionnaire and any other information collected in a confidential manner. There are risks associated with all vaccines.

Vaccines are offered either through our Vaccines for Children (VFC) program if child is eligible at no cost or through the child's insurance, if the child is insured. Return completed form to the school nurse prior to: __10/4/24_____.

**1) Please check which applies to your child:**

_____he/she has no insurance
_____he/she has insurance, but it does not cover these vaccinations
_____he/she is enrolled in Medicaid
_____he/she is an Alaskan native or Native American
_____he/she has third party insurance and it covers this vaccination.

**2) Katy Trail Community Health** will offer the following immunizations that are required for school participation and are recommended by the CDC.

## Seasonal Influenza Immunization

**3) CHILD'S INFORMATION:**

**Child's**

Name: _____ SS#_____ DOB: _____

Gender (Circle one please): Male Female

Street Address: _____ City: _____ Zip: _____

Phone: _____

Primary Care Provider: _____

**Primary Guardian:**

Name: _____ Relationship to Patient: _____

Street Address: _____ City_____ Zip: _____

Phone: _____

**Insurance:**

Name of Insurance company: _____ Policy #: _____ Group #: _____

Subscriber's Name: _____ Subscribers Birth Date: _____

Subscriber's SSN: _____ Subscriber's Address: _____

Subscriber's Phone Number: _____ Subscriber's Relationship to Patient: _____

***Please include a copy of all insurance cards*

Created: 2/22/2019, Updated: 2/22/23
Implemented: 2/22/2019

**4) PLEASE CIRCLE 'YES' OR 'NO'**

Yes No This child is allergic to medicines, foods, or vaccinations.
If yes please describe_____

Yes No This child has had a serious reaction to a vaccine in the past.
If yes please describe_____

Yes No This child or one of his/her immediate family member has seizures, brain-nerve problem, bleeding disorder or on aspirin or blood thinners.

Yes No This child has chronic lung, or asthma, or has had a history of asthma or wheezing in the past year.

Yes No This child is pregnant or could potentially be pregnant.

Yes No This child is currently breastfeeding.

Yes No This child has heart or kidney disease, diabetes, or other chronic illness.

Yes No This child has cancer, leukemia, AIDS or other immune system problem:

Yes No This child has taken cortisone, prednisone, other steroids or anticancer drugs or had X-ray treatments in the last six weeks.

Yes No This child had a transfusion of blood or blood products or has been given immune (gamma) globulin in the last six weeks.

Yes No This child has received vaccinations in the last four weeks.
If yes, which vaccinations_____

Yes No This child has a current fever or respiratory illness.

5) READ AND SIGN BELOW:

I have been given a copy of and have read or had explained to me, the information in the "Vaccine Information Statement(s)" for the disease(s) and vaccine(s) to be administered to this child. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to me or to the person named above for whom I am authorized pursuant to Section 431.058, RSMo to make this request.

**Parent/Guardian Signature: _____ Date: _____**

**Office Only- Administration Information:**

**Child's Name:_____ DOB: _____**

**VIS given date: _____ Temperature: _____**

| Vaccine | Date Given | Manufacturer | Dose | Site/Route | Lot Number | Expiration Date | Adm. Initials |
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**Administering Nurse Name:_____ Nurse Signature:_____**