# IMMUNIZATION CONSENT FORM

Before your child can receive the Influenza immunization, you must read this information sheet, answer the questions. If you would like your child to receive the influenza immunization from Katy Trail Community Health, please complete this form. Katy Trail Community Health will keep this questionnaire and any other information collected in a confidential manner. There are risks associated with all vaccines, please review the Vaccine Information Sheet attached. Like any immunization, it does not protect 100% of individuals immunized.

Immunizations 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 the administration date of: _Friday October 11, 2019__.

**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 not required for school participation, but 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: _____ Subscriber's Birth Date: _____

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

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

| | | |
|---|---|---|
| Yes | No | This child is allergic to medicines, foods, eggs, or vaccinations. |
| Yes | No | This child has had a serious reaction to a immunization in the past. |
| 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 has been diagnosed with Guillain-Barré syndrome. |
| Yes | No | This child 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 months. |
| 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 immunizations in the last four weeks. |
| 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.
By signing below I am acknowledging and agreeing to Katy Trail Community Health billing my insurance for this service.

**Parent/Guardian signature**:

_____Date:_____

**Administration Information:**

**Child's Name_____ DOB: _____**

| Immunization | Date Given | Brand Name | Dose | Site/Route | Lot Number | Expiration Date | Adm. Initials |
|---|---|---|---|---|---|---|---|
| Influenza | | | | | | | |

**VIS Date: _____**

Nurse: _____ School site: _____