Cincinnati Health Department
School and Adolescent Health Program
Consent Form for 2023-2024 Seasonal Influenza Vaccine

COMPLETE THIS FORM ONLY IF YOU WANT YOUR CHILD TO GET THE FLU VACCINE

A. SCHOOL NAME: _____

STUDENT NAME (Last)	(First)	(M.I.)	GRADE/HR

DATE OF BIRTH	AGE	GENDER M / F	RACE	PHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP

INSURANCE STATUS:
☐ **Medicaid** ☐ **CareSource** ☐ **United Healthcare Community Plan** ☐ **Molina** ☐ **Paramount** ☐ **Buckeye**
☐ **No Insurance** ☐ **Private Insurance** _____ **Insurance Billing#**_____
Medical Card Billing Number# _____ **Child's SS#**_____
*No student will be denied the flu vaccine due to inability to pay or lack of insurance

B. In order to determine if your child needs a booster dose, please answer this question**:**

1. Did your child receive **2 doses** of seasonal flu vaccine since July 2010? ☐ Yes ☐ No ☐ Unsure

C. Please answer all of the following questions:

	YES	NO
1. Is the student sick today with fever or respiratory illness?	☐	☐
2. Does the student have a serious allergy to eggs, thimerosal or another component of the flu vaccine?	☐	☐
3. Has the student ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Has the student ever had Guillain-Barré Syndrome (a temporary severe muscle weakness) within 6 weeks after receiving flu vaccine?	☐	☐

D. Please answer all of the following questions:

	YES	NO
1. Does the student have a long term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia or another blood disorder?	☐	☐
2. If the student is between the ages of 2 and 4 years old, in the past 12 months has a health care provider told you that he or she had wheezing or asthma?	☐	☐
3. Does this student have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as high dose steroids, or cancer treatment with radiation or drugs?	☐	☐
4. Does the person have close contact with someone who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	☐	☐
5. Is the person on long-term aspirin or aspirin-containing therapy (for example, does the person take aspirin every day)?	☐	☐
6. Is the student receiving anti-viral medications?	☐	☐
7. Is the person pregnant or could become pregnant in the next month?	☐	☐
8. Has the person received any of the following vaccinations within the past 30 days? MMR, Varicella, or Flu Mist? If yes, give type and date. Recent Vaccinations: _____ Date received: _____	☐	☐

E. Consent

CONSENT FOR VACCINATION:
I understand I will receive the **Flu Vaccine Information Statement** and be offered the **Cincinnati Health Department Notice of Privacy Practices prior to my child receiving the vaccine.**

I GIVE CONSENT for the student named at the top of this form to receive the Flu vaccine.

Signature of Person/Parent/Legal Guardian _____ Date: month _____ day _____ year_____
Print Name of Parent Legal/Guardian_____
Parent Cell Phone Number: _____

F: Vaccination Record (FOR ADMINISTRATIVE USE ONLY):

Vaccine	Date Dose Administered	Route	Lot Number	Name and Title of Vaccine Administrator
2023 Seasonal Flu	/ /2023	L Arm R Arm ☐ IM		
Booster Dose	/ /2023	L Arm R Arm ☐ IM		