If you want your student vaccinated for the FLU, complete this form and return it to your child's homeroom teacher. **ABS** **REF**

KNOX COUNTY TENNESSEE HEALTH DEPARTMENT

2022 Student FluMist Vaccine Consent Form
Please print in ink – all fields are required

Official Use Only	**Vaccine Source:** VFC KCHD	
	Naïve: Yes No	

Name - First: _____ MI: ___ Last: _____ Grade: ____ Teacher: _____

Age: _____ DOB: _____/_____/_____ SS#: _____-_____-_____ School: _____

Home Address: _____ ZIP Code:_____

Race: ☐White ☐Black ☐Asian ☐American Indian ☐Alaskan Native ☐Other:_____

Gender: ☐Male ☐Female Hispanic: ☐Yes ☐No Primary Language: _____

Primary Insurance (**MUST** Select One): ☐No Insurance ☐CoverKids ☐TennCare ☐Private Insurance

Primary Insurance Name: _____ Member ID: _____ Group ID:_____

Insurance Address/P.O. Box: _____ Insurance ZIP Code: _____

Subscriber Name: _____ Relationship to Insured: _____ Subscriber DOB: _____

Secondary Insurance (Select One): ☐No Secondary Insurance ☐CoverKids ☐TennCare ☐Private Insurance

Secondary Insurance Name: _____ Member ID: _____ Group ID: _____

Insurance Address/P.O. Box: _____ Insurance ZIP Code:_____

Subscriber Name: _____ Relationship to Insured: _____ Subscriber DOB: _____

Please Circle Yes or No. Answers are for the person getting the vaccine.		
1. Has your child had at least 2 doses of FLU vaccine during his or her lifetime? If unsure, mark No.	**Yes**	**No**
2. Has your child ever had a severe or life-threatening allergic reaction to the FLU vaccine such as wheezing or breathing problems? **If yes,** describe reaction:	**Yes**	**No**
3. Is your child allergic to eggs, gentamicin, arginine, gelatin, MSG or other FLU vaccine components? **If yes,** describe reaction:	**Yes**	**No**
4. Has your child ever been diagnosed with Guillain-Barre´ syndrome?	**Yes**	**No**
5. **In the past 30 days**, has your child had a vaccine for MMR, Varicella (Chicken Pox), or Yellow Fever? **Name of Vaccine(s):** **Date(s):**	**Yes**	**No**
6. Does your child have any of the following: (Please mark all that apply) ___ neurological/neuromuscular disorders ___chronic lung disease ___asthma/reactive airway disease ___wheezing in last 12 months ___regular use of inhaler ___chronic heart diseases ___kidney diseases/disorders ___liver disorders ___no spleen/asplenia ___diabetes/metabolic diseases/disorders ___blood diseases ___cochlear implant ___CSF leak ___weakened immune system, cancer, lupus or HIV/AIDS ___a medication that lowers the body's resistance to infection	**Yes**	**No**
7. Is your child pregnant?	**Yes**	**No**
8. Has your child currently/recently taken an antiviral medication for FLU or is your child on long-term aspirin therapy?	**Yes**	**No**
9. Does your child have close contact with severely immunocompromised persons who require a protective environment?	**Yes**	**No**

Consent for Administration of Influenza Vaccine for the above-named recipient: I have read information about the vaccine and special precautions on the Vaccine Information Sheet. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to myself or the person above of whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release Knox County Government, their affiliates, employees, directors and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination. This consent gives Knox County Health Department permission to file rendered services to your insurance carrier. Consent form is valid 6 months from date of initial signature. **For a copy of the Vaccine Information Sheet visit http://www.immunize.org/vis/flu_live.pdf.**

Parent Comments (continue on back if needed):

Parent /Guardian Signature: _____ Date: _____ Relationship to Minor: _____

Parent/Guardian - First Name _____ Middle Initial ____ Last Name _____

Primary Phone: ( ) _____-_____ Emergency Number: ( ) _____-_____ Revised 8/03/22

Official Use Only

VFC Patient Eligibility Screening Record - Verification Notes: Check all that apply ___ NOT Eligible for VFC Vaccine

____ Medicaid Enrolled ____ American Indian or Alaskan Native ____ *Has insurance that covers vaccines*
____ No Health Insurance ____ Underinsured ____ *CoverKids*
Date verified:____/____/2022

Drug Name: **FluMist 0.2 ml Sprayer** Amount: **0.2 ml** VFC KCHD
Mfr: **MedImmune** NDC: _____
LOT: _____ EXP: _____/_____/_____
VIS Date: 8/6/2021 Site: BL nares/ R L naris Route: **Intranasal**
Date Given: _____/_____/_____ Signature: _____
Provider ID: _____ Name: _____

Drug Name: **FluMist 0.2 ml Sprayer** Amount: **0.2 ml** VFC KCHD
Mfr: **MedImmune** NDC: _____
LOT: _____ EXP: _____/_____/_____
VIS Date: 8/6/2021 Site: BL nares/ R L naris Route: **Intranasal**
Date Given: _____/_____/_____ Signature: _____
Provider ID: _____ Name: _____