School Jarrett STEAM Academy **FLU IMMUNIZATION CONSENT FORM** **Grade**_____

Teacher_____ **Student ID#**_____

The Springfield School District, in cooperation with CoxHealth, is offering s**easonal flu vaccine** to any child who qualifies for the **Vaccines for Children (VFC) Program**, as supply allows. If you would like your child to receive the flu vaccine, please complete this form. All vaccines given at these clinics are provided free of charge.

The Inactivated Influenza (FLU Shot) will be administered.

1) QUALIFYING CHILDREN for VFC: Check which applies for your child (at least one must apply):

_____he/she has no insurance
_____he/she has insurance, but it does not cover vaccinations
_____he/she has Medicaid
_____he/she is an Alaskan native or Native American

In addition, for those students with **private insurance coverage** that fully covers vaccinations and therefore not qualifying for VFC, inactivated influenza vaccine (FLU shot) has been provided by CoxHealth, Springfield Greene County Health Department, and Mercy-Springfield and will be given free of charge. Please **check if your child has private insurance that pays fully for vaccinations (Not Medicaid)**

___ he/she **HAS** private insurance (not Medicaid) that pays fully for vaccinations.

Please review the Vaccine Information Sheet provided for inactivated influenza vaccine. If you have questions about the vaccine that are not answered on the Vaccine Information Sheet, please talk to your school nurse.

2) CHILD'S INFORMATION:

Child's Name:_____ SS#_____Gender: M F Race_____
Child's Date of Birth:_____Medicaid No:_____Language:_____
Child's Mother/Father/Guardian Name:_____ Date of Birth:_____Phone:_____
Child's Street Address:_____City_____Zip:_____

3) PLEASE CIRCLE 'YES' OR 'NO

1. Has your child received a vaccine within the past 30 days? Yes No
   If yes, please list name of vaccine(s):_____
2. Has your child received a flu vaccination before? Yes No
3. Is your child allergic to any part of the vaccine (eggs, egg proteins, gentamicin, gelatin, or arginine)? Yes No
4. Has the child ever had a life-threatening reaction to an influenza vaccine? Yes No
5. Is your child currently receiving aspirin or aspirin-containing therapy? Yes No
6. Does your child have asthma, recurrent wheezing, or active wheezing? Yes No
7. Has your child ever had Guillain-Barré syndrome? Yes No
8. Does your child have any diseases (for example, cancer, lupus, or HIV/AIDS) or take a medication (for example, steroids or chemotherapy) that lowers the body's resistance to infection? Yes No
9. Does your child have any of the following long-term health problems? (CHECK CIRCLE)
   ○ heart disease ○ kidney disease ○ metabolic diseases (for example, diabetes)
   ○ other_____
10. Is your child pregnant or nursing? Yes No
11. Please let us know if your child has close contact with anyone who has a weakened immune system (for example, an individual who has had a bone marrow transplant and is in a negative pressure hospital room). Please describe:
    _____

Allergies/medical alert: _____

4) READ AND SIGN BELOW:

Request for administration of inactivated Influenza (FLU Shot): I have been given the CDC Vaccine Information Statement. I have read this document and have no further questions at this time. I understand that my child will receive the inactivated Influenza (FLU shot) vaccine. I understand the risks and benefits of the inactivated intramuscular influenza vaccines. I request and voluntarily consent that the vaccine be given to the above-named recipient, of whom I am the parent or legal guardian, and I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the side effects and warnings of the vaccine.

Signature of Parent/Guardian _____Date ___/___/2024___

REV 09 16 2021 **Entered in eSchool by:_____(Initials)___/___/2024___(Date)**