

**KANAWHA-CHARLESTON HEALTH DEPARTMENT**  
**108 Lee Street, East, Charleston WV 25301**  
**2011 – 2012 Seasonal Influenza Vaccine**

**SHOT CONSENT FORM**

<b>Student's Name</b> _____			
(Last)	(First)	(Middle)	
<b>Current Address</b> _____			
(Street Address)			
_____		(State)	(Zip)
(City)			
<b>Date of Birth</b> _____	<b>Age</b> _____	<b>Gender</b> <u>M</u> _____ <u>F</u>	<b>Race</b> _____
Month//Day/Year			(optional)
<b>School Name</b> _____	<b>Grade</b> _____	<b>Teacher/Homeroom</b> _____	

**FLU SHOT SCREENING FORM**

Please review the Vaccine Information Sheet **BEFORE** completing this form. On the day of the vaccination clinic, If the child is ill with a fever, the nurse may decide to postpone the vaccination. Form must be completed by a parent or legal guardian.

1. Has your child ever received a Seasonal or H1N1 flu vaccine before?	<input type="checkbox"/>	<input type="checkbox"/>
a. If YES, has your child received the shot _____ or intranasal _____ or both _____		
b. If NO, your child has never had a flu vaccine, does he/she have any allergies?		
Describe _____		
2. Did your child have a <b><u>reaction</u></b> to an influenza vaccine before?		
<input type="checkbox"/> <input type="checkbox"/>		
a. If YES, Describe _____		
3. Has your child ever been paralyzed with a disease called Guillain-Barré Syndrome (GBS)?		
<input type="checkbox"/> <input type="checkbox"/>		
a. If YES, Describe _____		
4. Does your child have a severe allergy to eggs?		
<input type="checkbox"/> <input type="checkbox"/>		
a. If YES, check with your doctor to see if your child can receive the flu vaccine. (If your child can eat eggs, they can receive the vaccine).		
5. Does your child have an allergy to latex?		
<input type="checkbox"/> <input type="checkbox"/>		
a. If YES, Describe _____		

**Parent or Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature**

**PLEASE TURN PAGE OVER AND COMPLETE THE OTHER SIDE**

**Children 18 and under may qualify for state-supplied vaccine at a reduced rate. If the student is 18 or under, please complete this section of the form. If the student is 19 or older, please skip to next section.**

Parent/Guardian \_\_\_\_\_  
Last name First MI

This child is privately insured  Yes  No

This child is enrolled in WVCHIP and qualifies for state-supplied vaccine  Yes  No

This child qualifies for Immunization through the VFC Program because he/she (check only one):

Is enrolled in Medicaid

Does not have health insurance

Is an American Indian or Alaskan Native

Is underinsured (has health insurance that does not pay for vaccinations)

Primary Physician's Name \_\_\_\_\_  
Last name First MI

**ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES**

The KCHD Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice of Privacy Practices is subject to change. To obtain a copy of our Notice, you may visit our website at [www.kchdwv.org](http://www.kchdwv.org) or by calling (304) 348-8080. By signing this form, you acknowledge that the KCHD Notice of Privacy Practices was made available to you.

**CONSENT**

You must be at least 18 years of age to sign. If under age 18, a parent or guardian's signature is required. I have read or had explained to me the 2011-12 Vaccine Information Statement for the 2011-12 Influenza vaccine and understand the risks and benefits. I give consent for my child named at the top of this form to be vaccinated with this vaccine.

**INSURANCE INFORMATION**

**Name of Primary Insurance:** \_\_\_\_\_

**Policy Holder's Name** \_\_\_\_\_ **Relationship To Policy Holder** \_\_\_\_\_  
(Last) (First)

**Policy Holder Date of Birth:** \_\_\_\_\_ **Policy ID Number:** \_\_\_\_\_ **Group # (if any)** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Parent or Legal Guardian** **Date**

**Health Department Use Only**

Medical Screener Signature \_\_\_\_\_

Date \_\_\_\_\_

<b>Injection Site/Route</b>		<b>Manufacturer:</b>		<b>Lot#</b>	
<b>Date Vaccinated:</b>		<b>Vaccinator Signature:</b>			