MYRTUE Medical Center

Public Health Dept.
(712)755-4422

FLU VACCINE SHOT
2022-2023 SCREENING & CONSENT FOR SCHOOLS

rev 8/9/2022

Student's last name ___________________________First name _____________________________Middle name_______________

Date of Birth: _______________ Age: _____ Circle → Male or Female School/Building_____________ Grade/Room ____________

Address: ____City:_______________________, IA Zip_________________

Name of Parent or Guardian______________________________ Mother's Maiden name_________________________

Daytime phone: _________________________

Circle one choice below that pertains to this child:

- Is enrolled in Medicaid MCO and eligible this month? If Yes (no charge) → Must **attach a copy of your Medicaid card.**
- Does not have any health insurance (no charge)
- Has health insurance that DOES NOT pay for flu vaccines (no charge). **Must attach a copy of your insurance card.**
- Is American Indian or Alaskan Native or (no charge)
- OR:
- My child has insurance that pays for vaccine. If the insurance is Wellmark/Blue Cross-Blue Shield or Aetna, please fill in:

Blue Cross/Aetna ID # _____________________ Group # ___________________BCBS or Aetna Policy holder___________________

Policyholder's date of birth_________________ **Staple a copy of your Blue Cross or Aetna card to this consent form**.

If you have another kind of insurance that pays for vaccines please staple payment to the consent and ask for a receipt to submit to your insurance company. **Shot $54.75** **Cash or Check #**______________ ***Receipt given by*** ____________ *(initials)*

I agree to the following:

1. I have seen or been offered a copy of the current, appropriate Vaccine Information Sheet for Influenza.
2. To have the child's health insurance billed. If insurance doesn't pay for the whole amount, I agree to pay the difference later.
3. I accept responsibility for seeking medical attention for any problems with this vaccine.
4. The child getting the vaccine does not have a history of an allergic reaction after a previous dose of influenza vaccine and does not have any severe, life-threatening allergies.
5. The child getting the vaccine is not moderately to severely ill and does not have COVID symptoms.
6. The child does not have a fever.
7. The child has never had Guillain-Barre Syndrome.
8. If receiving FluMist: My child has not had a vaccine in the past 4 weeks. My child has not taken an antiviral vaccine in the previous 48 hours. My child is not on long-term aspirin therapy. My child does not have asthma. My child does not have a weakened immune system nor is in contact with someone with a weakened immune system. My child is not pregnant or possibly pregnant. My child does not have an underlying medical condition, such as liver, lung, heart, neurologic, metabolic, neuromuscular or kidney disorder.

I give permission for my child to receive an influenza vaccine at school.

Signature of parent/guardian:_____________________________________ **Date**_____________________

Date	Circle Source	Injection brand/type or sticker	Dose & Site IM or IN	Vaccinator	Date entered in IRIS Initials
	VFC or **Private**		0.5 ml Left or Right Deltoid OR .2ml IN		