PLEASE READ BEFORE COMPLETING THIS FORM.

Only complete the following consent form if you wish for your child to receive a flu injection.

If you have any questions please call the Sullivan County Regional Health Department at 423-279-2777

DO NOT return this consent form if your child will not be receiving the flu injection.

Sullivan County Regional Health Department (SCRHD) Flu Vaccine Program for Schools 2022-2023

423-279-2777

IMPORTANT!!! ***PHONE NUMBERS*** WHERE PARENT/GUARDIAN CAN BE REACHED DURING SCHOOL HOURS:

Work: ____________________ Cell: ____________________ Home: ____________________

STUDENT INFORMATION-PLEASE PRINT:

Last: ____________________ First: ____________________ MI____ Date of Birth: __________ Sex: M or F

Address: ______________________________ City: ____________________ ZIP: ______________

Social Security Number: ____________________

School: ____________________ Grade: ______

Homeroom Teacher: ____________________

Race: (Circle)

Caucasian African American American Indian

Asian Pacific Islander Other

Hispanic - Y or N

PLEASE CIRCLE YES** ***OR **NO** to all of the questions below to determine if your child can receive the inactivated flu vaccine (flu shot). The nurse giving the vaccine will review this information on the day the vaccine is given.

Question		
Has your child ever had a serious allergic reaction to any component of any flu vaccine (eggs, Gentamicin, gelatin, or arginine)?	YES	NO
Has your child ever had a serious reaction to any component of any flu vaccine in the past?	YES	NO
Has your child ever had Guillain-Barre Syndrome?	YES	NO
Does your child have any allergies? If yes please list:	YES	NO
Is your child under 9 years old? (If your child is under 9 years of age and has never been vaccinated against flu or has not been vaccinated with at least 2 doses of seasonal flu vaccine before July 1, 2022, your child will require 2 doses. (administer dose 2 even if the child turns 9 between receipt of dose 1 and dose 2). Please wait four weeks and call the Sullivan County Health Dept. to schedule your child's second dose of flu vaccine.)	YES	NO

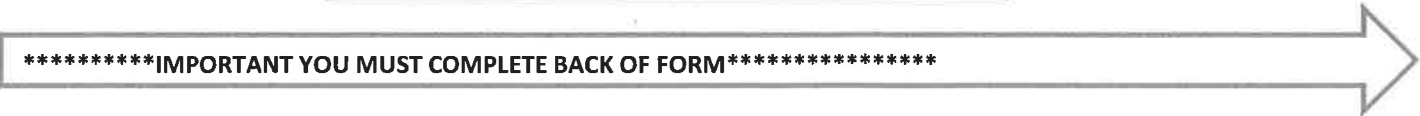
CONSENT FOR ADMINISTRATION OF INFLUENZA VACCINE FOR THE ABOVE-NAMED RECIPIENT

I have read the 2021 Vaccine Information Statement (**VIS**) for the Inactivated Flu Vaccine (Flu shot), I understand the risks and benefits, and I give consent to the Sullivan County Reg Health Department (SCRHD) and its authorized staff for my child named at the top of this form to receive the inactivated injectable influenza vaccine (flu shot). I will receive information about the vaccine and special precautions on **VIS** prior to my child receiving the vaccine and on the day of vaccination. I have read the Privacy Notice on the Health Dept. website www.sullivanhealth.org under tab **About US**. Furthermore, by signing I give permission for any insurance(s) to be billed for payment according to the SCRHD guidelines. I have had the opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to the person named above whom I am the parent or legal guardian. I acknowledge that no guarantees have been made concerning the vaccines success. I hereby release the City of Kingsport, Kingsport City Schools, the City of Bristol, Bristol City Schools, Sullivan County employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

I understand that this document will be given to and retained by the public health department. I give my permission for my child's school to retain a copy if needed.

SIGNAURE OF PARENT/LEGAL GUARDIAN: ______________________________ **Date:** ______________

PRINT PARENT/LEGAL GUARDIAN: ______________________________



Insurances Accepted for vaccination

Copy of insurance card preferred (front and back) if copy of insurance card is NOT available, complete ALL information below. Please list primary and secondary insurances if you have them.

Only NO INSURANCE and Insurances listed will be accepted

********Insurance information below must be completed********

NO INSURANCE check here ☐

TennCare Insurance Provider: (circle one)

1) BlueCare 2) Amerigroup 3) UnitedHealthcare Community Plan

CoverKids: (circle one)

1) Amerigroup Community Care 2) BlueCare TN 3) UnitedHealthCare Community Plan

Private Insurance Provider: (circle)

1) Blue Cross/Blue Shield 2) Cigna 3) Humana 4) United Health Care

Member / Subscriber ID: ______________________________

Member Subscriber Name as on card: ______________________________

Address to send medical claims to: (*information typically found on the back of the card*):

____

By signing the front of this paper I give the Sullivan County Regional Health Department (SCRHD) my permission to file all primary and secondary insurances for Flu vaccination. I authorize the release of any medical information necessary to process this claim. I also request that payment of insurance benefits for flu vaccine be paid directly to SCRHD. I have provided ALL insurance information to the Sullivan County Regional Health Department.

https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf → CDC VIS link

For questions or concerns, please call: (423) 279-2777

Area below for Official use ONLY

Manufacturer: __________ **VIS Date: 08/06/2021** **Other**__________

Lot number: __________ **Site administered:** **Right Deltoid** **Left Deltoid**

Date Given: __________ **Signature:** __________ **Provider #**__________

Signature Above indicates immunization given according to PHN Protocol

VFC	**←Circle One→**	**Private/CoverKids**
90460		**90460**
CH		**IT**
150		**FLU**