

SEASONAL FLU VACCINE

This form is to be completed by the parent or legal guardian of the child named below.

STUDENT INFORMATION				
Last Name:		First Name:		Grade:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	School:		
Home Address:			ZIP Code:	
City of Residence:		Parent/legal guardian full name:		
Daytime Phone:	Mobile:	I am the student's: <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian		
Email address (If available):				

HEALTH SCREENING
Has your child ever had a severe reaction to a vaccine? <input type="checkbox"/> No <input type="checkbox"/> Yes- describe:
Does your child have any severe allergies to medications, food, eggs , or latex? <input type="checkbox"/> No <input type="checkbox"/> Yes- describe:
Does your child have a condition that lowers immunity (cancer, leukemia) <input type="checkbox"/> No <input type="checkbox"/> Yes- describe:
Is your child taking medication that lowers immunity (cortisone, other steroids, radiation)? <input type="checkbox"/> No <input type="checkbox"/> Yes- describe:
Is your child currently receiving aspirin therapy? <input type="checkbox"/> No <input type="checkbox"/> Yes- describe:
Has your child been diagnosed with asthma or experienced recurrent wheezing? <input type="checkbox"/> No <input type="checkbox"/> Yes- describe:
Is your child pregnant or nursing? <input type="checkbox"/> No <input type="checkbox"/> Yes
Please check with your doctor if you are unsure of medical details. Please let us know about any changes in your child's medical condition on the day of vaccination.

CONSENT FOR VACCINATION
<p>I have read and understand the information provided to me about the vaccinations listed below, including risks and side effects. I GIVE CONSENT for my child, named at the top of this form, to get vaccinated with the vaccines I have checked below during the 2013-2014 academic year. I further understand the School that my child attends (named above) is not liable for the services or vaccinations administered by Health4Chicago.</p> <p style="text-align: center;"> <input type="checkbox"/> YES, I GIVE MY CONSENT for my child to receive influenza (Flu) vaccine <input type="checkbox"/> Flu Shot: Injection <input type="checkbox"/> Flu Mist: Nasal </p> <p style="text-align: center;"> <input type="checkbox"/> NO, I DO NOT GIVE MY CONSENT for my child to receive the seasonal influenza (Flu) vaccine. REASON: </p>

HEALTH INSURANCE	<input type="checkbox"/> MY CHILD DOES NOT HAVE INSURANCE
Name of Insured:	Insured's Date of Birth:
Medicaid #:	
Insurance Type (non-Medicaid):	<input type="checkbox"/> PPO <input type="checkbox"/> HMO
Insurance ID #:	Group #:
Employer Name:	

INTERNAL USE ONLY				
Vaccine	Date Administered	Site/ Route (Circle One)	Lot Number (Place Sticker)	Immunizer
		RA IM LA IM IN		

I opt out of my child's information being entered in to the Illinois Comprehensive Automated Immunization Registry Exchange, which allows Illinois providers access to my child's immunization records.

I agree to assign insurance benefits to the treating physician. Medical information may be released to my insurance company for the purposes of securing payment for services received. I understand it is my responsibility to understand my benefits and insurance coverage and I will be held responsible for any fees owed for services. **Children uninsured or covered by Medicaid will be given vaccines FREE of charge to parents.**

Parent/Guardian Signature

Date