School:_____

HealthHUB School Clinic

PO Box 542, South Royalton, VT 05068

Seasonal Influenza Vaccination Consent Form '20–'21

*If child is already a South Royalton Health Center patient, **only** complete Sections 1 & 3*

SECTION 1

Student's / Participant's Information:

Last Name _____

First Name _____

Student's Date of Birth _____

Student's Social Security # _____

Regular Primary Care Provider _____

Gender: ☐ Male ☐ Female

SECTION 2

Student's / Participant's Address and Phone:

Address _____

City _____

State _____ Zip _____

Primary phone (_____) _____

Regular Pediatrician _____

Parent's Address and Phone (if different from above)**:**

Name _____

Address _____

City _____

State _____ Zip _____

Primary phone (_____) _____

MEDICAL INSURANCE INFORMATION

Policy Guarantor/ Holder/subscriber:

Name: _____

Date of birth _____

Relationship to student: _____

Address _____

City _____

State _____ Zip _____

Primary phone (_____) _____

Primary Insurance: _____

City _____ State _____

Group # _____

Individual # _____

Copay requirements: _____

Secondary Insurance: _____

City _____ State _____

Group # _____

Individual # _____

Copay requirements: _____

Student's / Participant's Race:

☐ White/Non-Hispanic ☐ Black/Non-Hispanic

☐ Hispanic ☐ Asian/Pacific Islander

☐ Native American/Alaskan Native ☐ Unknown

☐ Other (specify) _____

☐ Prefer not to answer

SECTION 3

FLU VACCINE CONSENT:

1. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? ☐ Y ☐ N
2. Has the person to be vaccinated ever had Guillain-Barré syndrome? ☐ Y ☐ N

By signing this form I am agreeing that I have read the Seasonal Influenza vaccine Fact Sheet. I have answered the questions above to the best of my ability and I am aware of the risks and benefits to my child or myself. I give consent for the Seasonal Influenza Vaccination to be given to my child or myself at the HealthHUB School Clinic and my insurance to be billed.

Your signature: _____

Date _____

Email _____

Return completed form to school nurse/secretary.

PARENTS – COVID SCREENING

If you have traveled outside of Vermont in the last 2 weeks, or traveled on high-risk transportation (bus, plane or train), or have any of these symptoms: Cough/Shortness of breath/Congestion, Fever, Nausea/Vomiting/Diarhea, Change in sense of smell/taste, Muscle aches, Sore throat, **you cannot receive a flu shot today.**

For clinic use only:

Date of vax:_____ Site: ☐ LA ☐ RA Dosage: ☐ 0.25 ☐ 0.5 Lot #_____

Form updated 9/27/20, Gnaedinger