FOR SCHOOL USE: Room #: _____

STUDENT INFLUENZA CONSENT FORM 2018-2019

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR
COLUMBUS PUBLIC HEALTH

¿Necesita este formulario en Español? *Por favor consulte con la enferma de la escuela o a la oficina.*

Student Information (Print all information in black or blue ink.)

Student/Child Name *(First, Middle, Last)* _____

School Name _____

Student Date of Birth *(Month-Day-Year)* _____

Sex: ☐Male ☐Female ☐Prefer to self-describe: _____

Street Address _____

City _____

State OH

Zip Code _____

Home Phone (_____)

Cell Phone (_____)

one number is required

Student's Age _____

Student's Grade _____

Race and Ethnicity: Please check **all that apply** for your child:
☐ American Indian/Alaskan Native ☐ White ☐ Native Hawaiian/Pacific Islander
☐ Black or African American ☐ Asian ☐ Other: _____

Hispanic/Latino: *(check one below)*
☐ Yes ☐ No

Student's Main Language: ☐ English ☐ Spanish ☐ Somali ☐ Nepali ☐ Other: _____

Screening Information (Please check "yes" or "no" for each question)

	Yes	No
1. Is the child prone to fainting or light-headedness with shots or blood draws?		
2. Does the child have an allergy to eggs (egg protein)?		
If yes, can the child eat lightly cooked egg (such as scrambled egg) without reaction?		
If yes, did the child have *hives* (red, itchy raised patches of skin) *only* after exposure to eggs?		
If yes, has the child had a serious reaction (systemic [full body] or anaphylactic reaction such as hives, swelling of the lips or tongue, respiratory [breathing] distress or collapse) after eating eggs?		
3. Does the child have an allergy to any vaccine component (ex: polymycin, neomycin, gentamicin or gelatin)?		
4. Does the child have an allergy to latex?		
5. Does the child have any other allergies? ***If yes***, list:		
6. Has the child ever had a **serious reaction** after getting an influenza (flu) vaccine?		
If yes, describe what happened:		
7. Has the child ever had Guillain-Barré syndrome? *(rare condition affecting the immune and nervous systems)*		
8. **For children less than 9,** has the child **ever** received 2 or more doses of the flu vaccine before July 1, 2018? (If unsure, check "No".)		
9. ***Staff use only:*** Is the child sick today?		

Consent By Guardian

I have read or had explained to me the Influenza (Flu) *Vaccine Information Statement* and I understand the risks and benefits. I give consent to let Columbus Public Health give the influenza vaccine(s) to my child according to ACIP guidelines. **I GIVE CONSENT FOR MY CHILD (NAMED AT THE TOP OF THIS FORM) TO GET VACCINATED FOR ONE OR TWO DOSES AS NEEDED during the 2018-19 flu season, as determined by the CPH nurse.**

I acknowledge and assert that I am a parent or legal guardian of the student/patient named above, and I give permission for Columbus Public Health staff to treat and care for the needs of the above mentioned patient/student. I also understand that any care received outside Columbus Public Health (e.g., referred care) will not be paid for by Columbus Public Health. Administered immunizations will be entered into the statewide immunization information system (*Ohio ImpactSIIS*). I authorize the release of medical information necessary to process this claim for billing. I agree to pay my co-pay and for any charges not covered by insurance or grants, unless I sign the hardship waiver below.

I understand that the Privacy Notice of Columbus Public Health is available on the internet at www.columbus.gov/HealthPrivacyPolicy. I also can have it mailed to me by calling 614-645-2738.

Please turn page to sign and complete the form.

Student First Name Last Name

Signature

X_____ **X**_____ **X**____/____/____
Parent/Guardian *Printed Name* **Parent/Guardian** *Signature* Date

- OR - *(if student/patient is 18 years or older)*

X_____ **X**_____ **X**_____ **X**_____
Student (Patient) *Printed Name* **Student (Patient)** *Signature* Date Student Phone

**Any reference to 'my child' means 'myself' once a minor turns 18 years old.*

Health Insurance

Please check which insurance carrier your child is covered by or sign below if you don't think your child has insurance. The *Vaccines For Children* (VFC) *Program* provides free vaccines to children who are: Medicaid-eligible; without insurance; American Indian or Alaska Native; or underinsured. Medicaid and private insurance is billed when possible, but you will not be billed.

Medicaid Managed Care Plans *(check one below):* Managed Care ID#:_____

☐ buckeye health plan ☐ CareSource Health Care with Heart ☐ MOLINA HEALTHCARE ☐ PARAMOUNT ADVANTAGE ☐ UnitedHealthcare* Community Plan

Medicaid UnitedHealthcare, **not insurance from a job*

☐ **Ohio Medicaid:** Healthy Start Healthy Families 1-800-334-8680 MEDICAID # *(12 digits)*: __ __ __ __ __ __ __ __ __ __ __ __

☐ **The student does not have health insurance.** (*Sign for hardship waiver.)*
SIGN HERE: I am unable to pay for health services. X_____

☐ **Private Insurance** (other than Medicaid):
Information from insurance card*:* Insurance company: _____
Subscriber ID or member #: _____ Group #: _____
Name of person under whom child is covered: _____ Birth date of insured adult: _____
Phone # on insurance card: _____
Claims address on insurance card: _____

OFFICE USE ONLY:
NextGen #: _____ Influenza: R L Time: Lot: Sequence: 1 2

VFC Private ≥19 Administered by:

Comments:

Flu doses needed: 1 2

DOSE #2 Influenza: R L Time: Lot:

Administered by:

Comments: