CYPRESS-FAIRBANKS INDEPENDENT SCHOOL DISTRICT

# 2018-2019 Seasonal Flu Shot (IIV*) Vaccine Consent Form

Healthy Schools
Powered by CareDox

Complete this form and return it to your child's school, or sign up online at **cyfairisdflu.com**

PLEASE PRINT LEGIBLY. EVERY SECTION OF THIS FORM IS REQUIRED.

## Student Information

| Last Name | First Name, Middle Initial | Suffix | Name of School | Grade | Homeroom |
|---|---|---|---|---|---|
| Address | | | City | State | Zip Code |
| Birth Date (month/date/year) | Age | Sex | Demographic Information (Circle one): White American Indian/Native Alaskan Black Asian Hispanic Other | | |

## Parent Information

| Last Name | First Name, Middle Initial | Suffix | Email Address |
|---|---|---|---|
| | | | Home Phone Number |
| Relationship to Student | | | Cell Phone Number |

## Required Health Insurance Information

**There is no cost to you. We guarantee you a $0 copay. We are required to bill your insurance company for the vaccine.**

Circle one: Private Insurance Medicaid (ex: Aetna Better Health, Amerigroup, Community First Health Plan) No Insurance

| Insurance Company | Member ID |
|---|---|
| Policy Holder's Name | Policy Holder's Date of Birth |

## Medical Information

| | Check One |
|---|---|
| Is your child 4 years or older? | ☐ Yes ☐ No |
| Do any of the following apply to your child? (If you answer YES, your child cannot receive a Flu Vaccine at school, please contact your child's doctor)<br>• Allergy to chicken eggs or egg products<br>• Life threatening reaction(s) to flu vaccine in the past<br>• Allergy to Latex<br>• Has had Guillain-Barre syndrome (very rare) | ☐ Yes ☐ No |
| Do any of the below apply to your child?<br>Has long-term health problems with weakened immune system, heart disease, lung disease (e.g. cystic fibrosis), liver disease, kidney disease, or metabolic disorders (e.g. diabetes) or blood disorders (e.g. sickle disease or thalassemia) | ☐ Yes ☐ No |

If you have any health questions, please contact your child's pediatrician or call Healthy Schools LLC at 1-800-566-0596 to speak to a nurse. I have received, read, and understand the CDC Vaccine Information Statement for the Inactivated Influenza Vaccine (IIV). I have read these documents and understand the risk and benefits of the IIV vaccine. I give permission to Healthy Schools and their administrators to give my child the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing and storage according to Texas Department of State Health Services policies. I hereby release Healthy Schools from any and all liability associated with the administration and potential side effects of the vaccine. I understand that my child and Healthy Schools will be creating a provider-patient relationship. By providing my cell phone I understand that I may be contacted at that number, including text messages, with information regarding Healthy School's services.

☐ **YES, I want my child to receive a no-cost, in-school flu shot.**

Printed Name of Parent/Guardian ______________ Signature of Parent/Guardian ______________ Date ______________

The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry. Consent for Registration of Child and Release of Immunization Records to Authorized Entities. I understand that, by granting the consent below, I am authorizing release of the child's immunization information to DSHS and I further understand that DSHS will include this information in the state's central immunization registry ("ImmTrac2"). Once in ImmTrac2, the child's immunization information may by law be accessed by:

- a public health district or local health department, for public health purposes within their areas of jurisdiction;
- a physician, or other health-care provider legally authorized to administer vaccines, for treating the child as a patient;
- a state agency having legal custody of the child;
- a Texas school or child-care facility in which the child is enrolled;
- a payor, currently authorized by the Texas Department of Insurance to operate in Texas, regarding coverage for the child.

I understand that I may withdraw this consent to include information on my child in the ImmTrac2 Registry and my consent to release information from the Registry at any time by written communication to the Texas Department of State Health Services, ImmTrac2 Group – MC 1946, P. O. Box 149347, Austin, Texas 78714-9347.

☐ Yes ☐ No I wish to INCLUDE my child's information in the Texas immunization registry.

## AREA FOR OFFICIAL USE ONLY

| VIS CDC IIV | IIVt0.5L IM Injection | |
|---|---|---|
| LOT Number | Expiration Date | |
| RN # | Date | Circle One: RUA LUA |

*Inactivated Influenza Vaccine