2024-25 STUDENT INFLUENZA VACCINATION CONSENT FORM
INACTIVATED INFLUENZA (IIV) ONLY

VDH VIRGINIA DEPARTMENT OF HEALTH

Name: _____ Gender: ❑ M ❑ F
Last First Middle

Date of Birth: ____/____/____ Age: ____ Hispanic/Latino Y or N Race:_____

If minor - parent/guardian's name: _____
Last First M.I.

Parent/Guardian's Date of Birth: ____/____/____ Parent's SSN: _____ - _____ - _____
optional

Address: _____ City/State: _____ ZIP: _____

Grade: _____ Home Room Teacher: _____ School: _____

IMPORTANT Parent/Guardian Phone # Home: _____ Cell: _____ Work: _____

Please check YES or NO to all the questions below to determine if your child can receive the Inactivated Influenza Vaccine ("flu shot"). The nurse giving the vaccine will review this information on the day of the vaccine clinic.

	YES	NO
1. Has your child ever had a serious allergic reaction to any component of any flu vaccine (eggs, gentamicin, gelatin and arginine)?	☐	☐
2. Has your child ever had a serious reaction to a previous dose of flu vaccine in the past?	☐	☐
3. Has your child ever had Guillain-Barré syndrome (GBS, i.e., progressive ascending paralysis)?	☐	☐

If you answered YES to any of questions 1, 2 or 3 above about serious allergy to any component of flu vaccine, serious reaction or GBS, flu vaccine may not be safe for your child, and s/he WILL NOT receive a flu vaccine in this setting. If your child has a severe life-threatening allergy, please speak with your child's doctor before consenting to vaccination.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:
1. If any VDH health care professional, worker or employee should be directly exposed to your child's blood or body fluids in a way that may transmit disease, I understand that the law requires my child to give a venous blood sample for further tests. I understand that the tests to be performed are for human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. 2. If your child should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the tests. I consent to such testing and the release of the test results to the person who was exposed.

CONSENT FOR CHILD'S VACCINATION: In September 2024, will your child be less than 9 years of age? No ❑ Yes ❑

Please complete the next set of questions and sign.

My child is **under 9 years of age** and:

☐ has NEVER been vaccinated against the flu. **Note: Your child will require 2 doses this year**.

☐ has not been vaccinated with at least 2 doses of seasonal influenza vaccine before July 1, 2024. **Note: Your child will require 2 doses this year.**

☐ neither of the above is applicable.

I have read the Vaccination Information Statement (VIS) for the Inactivated Influenza Vaccine (flu shot), I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the inactivated injectable influenza vaccine (shot**). If needed, I give my consent for my child to receive the second dose approximately 4 weeks after the first.**

Signature of Parent or Legal Guardian: X _____ **Date:** ____/____/____

Turn to Back of Form

Insurance*: Please answer the following: This information is required for federal funding purposes for VFC vaccines.

***Note**: Vaccines will be provided to your child without cost to you if your child is eligible for the Vaccines for Children Program. If your child is covered by insurance, including Medicaid, the Department is required by law to seek reimbursement from the insurance plan for all allowable costs associated with the provision of the vaccine. You may be billed for any charges not covered by insurance.

My child:
- ☐ is *not* insured (by private insurance, Medicaid, or FAMIS)
- ☐ is American Indian or is an Alaska Native
- ☐ has Medicaid - Medicaid #: _____
- ☐ has FAMIS - FAMIS #: _____
- ☐ has other insurance not listed above (specify plan) _____

Policy ID # _____Policy holder's name_____

Attach a copy of the front & back of insurance card or provide the following information:

Insurance company address _____

Insurance company phone number_____

Office of Privacy and Security

Authorization for Disclosure of Protected Health Information

This consent gives the Virginia Department of Health (VDH) permission to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to my child cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me or my child will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my child's health information to his/her primary care physician and school.
- I understand that this record will be retained until my child reaches 21 years of age.
- I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third-party payer to pay any authorized benefits to VDH on my behalf.
- I understand this document will be given to and retained by the public health department and will not be maintained by the school.

❑ Please check box if you wish to receive a copy of the Virginia Department of Health Privacy Rights.

Please send a copy of my child's immunization record to her/his doctor at the following address.

*Doctor's Name*_____

*Mailing Address*_____*City*_____ *State*_____ *ZIP*_____

8/20/2024

HEALTH DEPARTMENT USE ONLY

Date	Item code	Funding Source	Lot Number	Vaccine Administration Site	Provider #
		VFC STATE 317 LHD (chargeable)		RA LA	
Comments					
Provider Name/Signature and Date					