Parental Consent for Influenza (Flu) Vaccination

Patient's LAST name _____ FIRST name _____ Date of Birth _____

Grade

❑ PreK ❑ K ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 ❑ 11 ❑ 12

Campus: _____ Homeroom Teacher: _____

I, the undersigned, as the parent/legal guardian of the student named above, having the legal authority to make medical decisions on their behalf, do hereby give my full consent for this student to receive the influenza (flu) vaccine. I have read the information about the vaccine and precautions on the Vaccine Information Sheet (VIS). I am aware that I can locate the most current VIS and other information at www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I acknowledge there are no guarantees concerning the success of the vaccine. Additionally, I do hereby waive, release, and hold harmless the school district, Access Family Health Services, Inc., Access School Health Services, their board members, directors, contractors, and employees from any liability or potential cause of action concerning any bodily, injury, disability, death, or loss or damage to person occurring as a result of this students participation in the vaccination program and the activities incidental thereto, whether the result of negligence or any other cause. Further, I understand the school district, Access Family Health Services, Inc., Access School Health Services, their board members, directors, contractors, and employees shall not be liable in any way. I am solely responsible for any associated medical costs not covered by insurance. I further certify that this student has no medical or physical condition that could interfere with safely receiving the vaccine, or else I certify that I am willing to assume risks and bear the costs that may be created, directly or indirectly, by any such condition. I understand this consent is valid for 6 months, and I will make Access Family Health Services, Inc. (Access School Health Services) aware of any health changes before the vaccination date. I understand the health-related information on this form may be governed by the regulations established under HIPAA. Protected Health Information (PHI) will be used and disclosed solely for insurance billing and reporting purposes. I certify that the information provided on this form is true and accurate to the best of my knowledge. I have read and understand this entire document, and I agree to be bound by its terms.

_____
Parent/Guardian's name (**PRINT**, please)

_____ ____/____/____
Parent/Guardian's signature Date

_____ _____
Insurance name Insurance ID#

This section for clinical use only.

GSK _____ _____ 06/30/2021
Vaccine Manufacturer Lot# Expires

Administered in the [❑ left • ❑ right] [❑ deltoid • ❑ gluteal] **by** _____.

Rev: 09152020 VIS: 08152019