STUDENT INFLUENZA CONSENT FORM 2016-2017

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

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

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

School Name _____

Parent/Guardian Name *(if Patient/Student is less than 18 years)* _____

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

Street Address _____ **City** _____ **State** OH **Zip Code** _____

Home Phone (_____)_____ **Cell Phone** (_____)_____ **Student's Age** _____ **Student's Grade** _____

Sex: ☐Male ☐Female ☐Other: _____

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)?		
Does the child have an allergy to latex?		
Does your child have any other allergies? ***If yes***, list:		
4. Has the child ever had a serious reaction after receiving an influenza (flu) vaccine in the past?		
If yes, describe what happened:		
5. Did the child receive 2 or more doses of the seasonal influenza vaccine before July 1, 2016?		
6. Has the child ever had Guillain-Barré syndrome (rare condition that affects a person's immune system and nerves)?		
7. ***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 2016-17 flu season, as determined by the CPH nurse.**

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 can also have it mailed to me by calling 614-645-2738.

Please turn page to sign and complete form.

Student First Name _____ Last Name _____

Signature

X_____ X_____ X_____ X_____
Parent/Guardian *Printed Name* | Parent/Legal Guardian *Signature* | Date | Phone

Relationship to Student: ☐Mother ☐Father ☐Legal Guardian

- OR -

X_____ X_____ X_____ X_____
Student (Patient) *Printed Name* | Student (Patient) *Signature* (**if 18 years or older**) | Date | 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

☐ **Ohio Medicaid:** Healthy Start Healthy Families 1-800-334-8680 OHIO 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:

SCHOOL USE ONLY: Room # _____