INFLUENZA/HEPATITIS A VACCINATION CONSENT *(Please Print)*

SCHOOL______________________________ **GRADE**______**TEACHER**____________________________

LAST NAME ____FIRST NAME______________________________MIDDLE _________

ADDRESS ____CITY ____________________________ STATE _____ ZIP __________

BIRTHDATE_____/_____/_____ AGE_________ SEX___________ RACE____________

Parent/Guardian Information
LAST NAME _________________________________FIRST NAME ____________________________PHONE (_____) ________________

______**ELIGIBLE FOR FREE VFC VACCINE BECAUSE:** (***check one***)

____**American Indian/Alaskan Native** *
____**No Health Insurance** *
____**Insurance Does Not Cover Vaccines** *

* Attach $20 cash, or a check made payable to *"JCHD"* to cover the administration fee, ***OR*** check the box below, if you are unable to pay the fee.

☐ **I am unable to pay the $20.00 administration fee**

____**Medicaid** *MUST give ID #* ____

_______**INSURED**

Circle company name and fill in policyholder information

Aetna Anthem Cigna Custom Design Benefits Encore Humana MedBen
Sagamore Siho TriCare United Healthcare

Policy holder's name ____________________________*ID #* (DO **NOT** PUT GROUP #)____________________________________

_______**PAY FOR SERVICES WITH CASH OR PERSONAL CHECK**

Make check payable to *"JCHD"*.
$25.00 Influenza Vaccine

HEALTH SCREENING: ***Answer all questions about the child receiving the vaccine.***

Yes No Does the child have any allergies to eggs or any component of the influenza vaccine?
Yes No Has the child had a serious reaction to the influenza vaccine in the past?
Yes No Has the child ever had Guillain-Barré Syndrome?
Yes No I would like for my child to receive the Hepatitis A vaccine, if necessary.

I have read the VIS statements for the vaccine(s) to be administered and understand the benefits and risks of the vaccine(s).
I authorize the staff of JCHD to administer the Influenza and/or Hepititis A vaccine (as indicated) to the person named above.
I acknowledge receipt of the "Notice of Health Information Privacy Practices". *(Paper copy available at JCHD)*
If applicable, I authorize JCHD to bill my health insurance and request payment of authorized insurance benefits be made directly to JCHD. I understand if insurance does not cover services that I will be responsible for payment of these services.

SIGNATURE *(Parent/Guardian if patient under 18 yrs)* **X**____**DATE** _________________

FOR OFFICE USE ONLY

VFC

90686 FLUARIX
6 mos and older, quadravalent PF — GSK
Route: Intramuscular — 2DB5X
Site: R Arm L Arm — Exp. 06/30/20

Hep A

90632 HAVRIX
GSK
9TL92
Exp. 05/27/21
Route: Intramuscular
Site: R Arm L Arm

PRIVATE

90686 FLULAVAL — GSK
6 mos and older, quadrivalent — 27SL2
Route: Intramuscular — Exp. 06/30/20
Site: R Arm L Arm

90672 FLUMIST
2 yrs – 49 yrs, quadrivalent — MedImmune
Route: Nasal — LJ2229
Exp. 01/08/20

Date Administered______________________ **Vaccinator Signature**____