CLEVELAND METROPOLITAN 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 **clevelandmetroflu.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: Buckeye Community Health Plan, UnitedHealthcare Community 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) • Allergy to chicken eggs or egg products • Life threatening reaction(s) to flu vaccine in the past • Allergy to Latex • Has had Guillain-Barre syndrome (very rare)	☐ Yes ☐ No
Do any of the below apply to your child? 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 Ohio Department of Health 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. Healthy Schools follows state requirements to register immunizations with ImpactSIIS, the Ohio Immunization Registry. For more information please visit: https://secure.caredox.com/l/OhioSIIS

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

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

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