Georgia Department of Public Health
Echols County

# 2026-2027 School Based Influenza Vaccine Consent Form

## Echols County Health Department

If you do NOT want your child to receive flu vaccine, do NOT fill out or return form.

## Section 1: Information on Student to Receive Influenza Vaccine

PT Record #: _____
*(Clinic Use Only)*

| | | | | |
|---|---|---|---|---|
| NAME (Last) | (First) | (M.I.) | SCHOOL NAME: | |
| DATE OF BIRTH (mm/dd/yyyy) | AGE | GENDER: M / F | HR Teacher Last Name | GRADE |
| ETHNICITY *(Please Circle)*<br>Not Hispanic/Latino Hispanic Latino | RACE *(Please Circle):* African American, White, Hispanic or Latino, American Indian, Asian, Alaska Native, Native Hawaiian, Other Pacific Islander, Other | | PARENT/ LEGAL GUARDIAN NAME | |
| HOME ADDRESS | | | PARENT/ GUARDIAN PHONE NUMBER(S) | |
| CITY STATE | | ZIP CODE | PARENT/ GUARDIAN E-MAIL | |

**INSURANCE INFORMATION: Do you have insurance that covers vaccines?** ☐ Yes / ☐ No

**Please check health insurance provider below:**

☐ Aetna ☐ Caresource ☐ PeachState ☐ No Insurance
☐ Ambetter (not Select) ☐ Cigna ☐ Tricare
☐ Amerigroup ☐ Medicaid ☐ United Healthcare/UMR
☐ Anthem BCBS ☐ Medicare ☐ Other _____

**Provide the insurance information for the provider selected and *attach a copy of the insurance card to this form.***

Policy Holder Name_____
Policy Holder DOB _____
Member ID #_____
DOD # (of dependent)_____

## Section 2: Medical Information

*The following questions will help us to determine if this student can receive the influenza vaccine.*

***Please circle yes or no for each question.**

| | | | |
|---|---|---|---|
| 1. | Has the student received any vaccines in the last four weeks? If yes, please list: | Yes | No |
| 2. | When was the student last vaccinated for flu? | | |
| 3. | Has the student ever had a serious reaction to eggs? | Yes | No |
| 4. | Has the student ever had a serious reaction to an influenza vaccine? | Yes | No |
| 5. | Does the student use an inhaler or receive breathing treatments for asthma or a wheezing condition? | Yes | No |
| 6. | Is the student on long term aspirin or aspirin-containing therapy? (For example: does the student take aspirin everyday) | Yes | No |
| 7. | Does the student have any significant or chronic (long term) health conditions? (For example: diabetes, sickle cell disease, heart conditions, lung conditions, seizure disorders, cerebral palsy, muscle or nerve disorders) | Yes | No |
| 8. | Is the student receiving influenza antiviral medications? | Yes | No |
| 9. | Does the student have a weak immune system? (For example: from HIV, cancer, or medications such as steroids or those used to treat cancer)? | Yes | No |
| 10. | Is the student or could the student be pregnant? | Yes | No |
| 11. | Has the student ever had Guillain-Barre Syndrome (GBS)? | Yes | No |

## Section 3: Consent

***If this consent form is not filled out completely, signed, dated and returned the student will not be vaccinated at school.***

**I GIVE CONSENT** to Echols County Health Department ***for the student named above to receive the influenza vaccine.*** I acknowledge that the student and medical information provided above is correct. I have been given a copy of the Vaccine Information Statement for the influenza vaccine and the NOTICE of PRIVACY POLICY FORM. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine that will be given to the student that I am authorized to represent. I understand that participation and receipt of the influenza vaccine through this program is completely voluntary. I understand that it is my responsibility to notify the school and the participating health department at least three business days prior to the school-based flu vaccination clinic event if my child has already received a flu vaccine by another provider this year. By signing below, I give permission for the student listed above to receive the injectable influenza vaccine. I give South Health District permission to file my insurance for services rendered.

***Signature of Parent/Legal Guardian:*** _____ ***Date:*** _____

**FOR CLINIC USE ONLY**

☐ **Private Stock** ☐ **VFC Eligible** ☐ **Non VFC** ☐ **Student will need a second dose**

Inactivated Influenza Vaccine 2026-2027 VIS **1/31/2025**

Administration Route: IM LA / RA

☐ Date Dose Administered: _____

☐ Dose Not Administered due to: _____

☐ Inactivated Influenza Vaccine – Trivalent ($IIV_3$)

Mfg: _____ Lot #:_____ Exp. Date:_____

Signature of Nurse: _____Date:_____


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