Georgia Department of Public Health
Lowndes County

2026-2027 School Based Influenza Vaccine Consent Form

Lowndes 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)* 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 Lowndes 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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