

Flu Season! Flu Season!

October 28, 2021

Parents/Guardians,

Marion County Health Department will be at Richard Hardy November 8th to give Flu Vaccine to our students.

Please complete the Student Consent Form by November the 2nd and return to the school. Marion County Health Department will pick up forms.

Benefits

- Parent/Guardian will not miss work.
- The student(s) will not miss school.

I ENCOURAGE you to have your student VACCINATED.

Thank you,

Regina Smith, RN

423-837-7282 (106)

Flu shots are coming to your child's school.

- The health department will be giving flu shots in your child's school soon at no cost.
- If you want your child to get a flu shot at school...
 1. Complete the front side of the blue form.
 2. Return the blue form to your child's school.
- You will be informed when flu shots will be given at your child's school.
- Flu shots will not be given without consent.
- If you have questions, call the health department.



**Tennessee Department of Health School Located Influenza Vaccination Project
Student Consent Form & Influenza Documentation Form**

If you want a Flu Vaccination given to your child, COMPLETE THE INFORMATION ON THE FRONT AND BACK OF THIS FORM AND SIGN. If NO, stop here and discard the form

Please Print

School:		Home Room Teacher:	Grade:
Student Last Name:		First Name:	MI:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB: / /	Current Age:	
Race: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other:		Ethnicity: Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address:	City:	State:	Zip:
Parent/Guardian Last Name:		First Name:	MI:
Parent Guardian Home Phone:		Cell Phone:	

ALL QUESTIONS MUST BE COMPLETED BY CHECKING YES OR NO IN ORDER FOR THE STUDENT TO RECEIVE A FLU VACCINE
The Nurse giving the vaccination will review the information on vaccination day.

1.	Has your child ever received a flu vaccine? If yes, when:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Has your child received at least 2 seasonal influenza (flu) vaccine doses prior to last July 1?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Has your child ever had a serious reaction to the flu vaccine in the past? If yes, when:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Does your child have any allergies to food or medicine? If yes, list allergies:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Does your child have an allergy to any components of the flu vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Has your child ever had Guillain-Barre' syndrome? (Muscle weakness, reflex loss and numbness or tingling in any part of the body)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Has your child received any other vaccinations in the past 4 weeks? Name of vaccine(s): Where: Date Given:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	In the past 12 months, has a healthcare provider told you that your child had wheezing or asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	Does your child have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes) or anemia or another blood disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	In the past 3 months, has your child taken medications that weaken the immune system, such as cortisone, prednisone or anticancer drugs; or have they had radiation treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	Does your child live with or expect to have close contact with a person whose immune system is severely compromised, and who must be in a protective isolation, (e.g., such as isolation room for a bone marrow transplant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13.	Is your child receiving aspirin therapy or aspirin containing therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14.	Is your child receiving any prescription medications to prevent or treat flu? If yes, list:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15.	Is your child pregnant or does she expect to be pregnant within the next month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Additional notes:

Request for Administration of Influenza Vaccine for the above named recipient: I received information about the vaccine and special precautions on the Vaccine Information Sheet prior to my child receiving the vaccine and on the day of vaccination. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent that the vaccine be given to the person above of whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release Tennessee Department of Health, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

I understand that this document will be given to and retained by the Tennessee Department of Health. I give permission for my child's school to retain a copy if needed. I acknowledge that I have been given the Department of Health's Notice of Privacy Practices.

This Consent Form is valid for administration of influenza vaccinations for twelve (12) months. It may be used to administer a second dose of influenza vaccine, if needed. I understand that I should report any changes of the above information to the health department prior to vaccination.

Parent/Guardian Signature: _____ Date: _____

PLEASE COMPLETE BACK OF FORM



