



2019-2020 Seasonal Flu Shot Vaccine Consent Form

I acknowledge that Aurora Concepts provided me and I have been afforded the opportunity to read the Notice of Privacy Practices and CDC Vaccine Information Statement for the Inactivated Influenza Vaccine (IIV) on their website: www.auroraconcepts.net under the 'Patient Resources' tab.

I give permission to Aurora Concepts 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 Texas Department of Health policies, to assure optimal healthcare for my child. I hereby release Aurora Concepts, and my child's school district from any and all liability associated with the administration and potential side effects of the vaccine.

YES, I wish to for my child to receive the flu vaccine. (please complete this form) **NO, I do not wish for my child to receive the flu vaccine. (do not proceed with form)**

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

Full, Legal Name of Student (First Name Middle Initial. Last Name) PLEASE PRINT		Name of School		
Parent/Guardian Name (First Name Middle Initial. Last Name)		Relationship to Student		Homeroom Teacher / Grade
Address		Email Address		Birth Date (month / date / year) Age Sex
City		Zip Code		Home Phone # Cell Phone #

Please CHECK ONE and fill out the following questions

Insurance CHIP/STAR/Medicaid American Indian/Alaskan Native

Underinsured (insurance does not cover Flu vaccine) My child does not have health insurance \$5 Administrative Fee requested date of clinic

Insurance Company: _____ Member ID: _____
Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

The current health care laws require us to bill your insurance company for the vaccine. There will be no out of pocket expense for those insured.

QUESTIONS : CHECK YES OR NO FOR EACH QUESTION

Yes <input type="checkbox"/>	No <input type="checkbox"/>	1.) Is your child 4 years or older?
Yes <input type="checkbox"/>	No <input type="checkbox"/>	2.) 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 <input type="checkbox"/>	No <input type="checkbox"/>	3.) 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)

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL AURORA CONCEPTS AT 936-598-3296 TO SPEAK TO A NURSE.

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

VIS CDC IIV _____	.IIV 0.5 ML IM Injection (Flulaval)
LOT NUMBER _____	EXP DATE _____
VACCINE MANUFACTURER _____	TITLE OF VACCINE ADMINISTRATOR _____
SIGNATURE _____	DATE _____ (RD IM) OR (LO IM)