2014-15 STUDENT INFLUENZA VACCINATION CONSENT FORM

IIV & LAIV or LAIV ONLY

Name: ____
Last First Middle

Health Department Use Only
CI #: ______
Encounter #: ______
Receipt #: ______

Date of Birth: ____/____/____ Age: ____ Gender: ☐ M ☐ F

If minor - parent/guardian's name: ______________________
Last First M.I.

Parent/Guardian's Date of Birth: ____/____/____ Parent's SSN: ______ - ____ - ________
optional

Address: ______________________ City: ______________ ZIP: ________

Grade: ______ Home Room Teacher: ______________________ School: ____________

IMPORTANT Parent/Guardian Phone # Home: ____________ Cell: ____________ Work: ____________

Please check YES or NO to all of the questions below to determine if your child can receive the Intranasal Influenza Vaccine (FluMist® – "nasal spray") or the Inactivated Influenza Vaccine ("flu shot"). The nurse giving the vaccine will review this information on the day of the vaccine clinic.

	YES	NO
1. Has your child ever had a serious allergic reaction to any component of any flu vaccine (eggs, gentamicin, gelatin, and arginine)?	☐	☐
2. Has your child ever had a serious reaction to a previous dose of flu vaccine in the past?	☐	☐
3. Has your child ever had Guillain-Barré syndrome (GBS, i.e., progressive ascending paralysis)?	☐	☐

If you answered YES to any of questions 1, 2 or 3 above about a serious allergy, reaction or GBS, flu vaccine may not be safe for your child and s/he WILL NOT receive a flu vaccine. If you answered NO to questions 1, 2 or 3, please continue below.

	YES	NO
4. If your child is between 2 – 4 years, in the past 12 months has a healthcare provider ever told you that your child had wheezing or asthma?	☐	☐
5. Does your child have a long-term health problem such as heart disease, kidney or liver disease, lung disease, metabolic disease (e.g. **diabetes**), or blood disorders (e.g. **anemia**)?	☐	☐
6. Does your child have a weakened immune system because of cancer, cancer treatment (e.g. x-rays or drugs), HIV/AIDS, other disorders, or medicine (e.g. high dose steroids)?	☐	☐
7. Does your child live with or expect to have close contact with a severely immunosuppressed person requiring a protective environment (e.g., an isolation room of a bone marrow transplant unit)?	☐	☐
8. Is your child taking aspirin or other aspirin-containing products?	☐	☐
9. Is your child taking any prescription medications to prevent or treat flu?	☐	☐
10. Has your child received a MMR (measles/mumps/rubella) and/or varicella (chickenpox) vaccination within the past 4 weeks?	☐	☐
11. Is your child pregnant or could she become pregnant within the next month?	☐	☐

If you answered YES or left blank any questions from # 4 through # 11 or if your child is younger than 2 years old, your child WILL NOT receive FluMist®, but she/he CAN RECEIVE the flu shot.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any VDH health care professional, worker or employee should be directly exposed to your child's blood or body fluids in a way that may transmit disease, your child's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If your child should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

Insurance*: Please answer the following:
Note: This information is required for federal funding purposes for VFC vaccine. It will not prevent your child from receiving vaccines through this program.

My child: ( ) is *not* insured (by private insurance, Medicaid, or FAMIS)
( ) is American Indian or is an Alaska Native
( ) has Medicaid - Medicaid #: ____________
( ) has FAMIS - FAMIS #: ____________
( ) has other insurance not listed above (specify) ____________ ID # ____________

Medicaid HMO Name ____________
Medicaid HMO # ____________
Group # ____________

I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third party payer to pay any authorized benefits to VDH on my behalf.

CONSENT FOR CHILD'S VACCINATION: In October 2014, will your child be less than 9 years of age? No ☐ Yes ☐
Please complete the next set of questions and sign.
☐ My child is **over 9 years of age.** I understand my child will receive one dose of influenza vaccine.

My child is **under 9 years of age** and:
- ☐has NEVER been vaccinated against the flu. **Note: Your child will require 2 doses this year.**
- ☐ has not been vaccinated with at least 2 doses of seasonal influenza vaccine since July 1, 2010. **Your child will require 2 doses this year.**

I have read the 2014-2015 Vaccination Information Statements (VIS) for the influenza shot and for the nasal spray. I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to get vaccinated with this vaccine. I prefer my child be given the (please check one) ☐ flu shot, ☒ flu mist. I understand the decision on the type of vaccine administered will depend on my child's history. If needed, I give my consent for my child to receive the second dose 4 weeks after the first.

Signature of Parent or Legal Guardian: X ____________ **Date:** ___/___/___

Office of Privacy and Security
Authorization for Disclosure of Protected Health Information

As the person signing this authorization, I understand that I am giving permission to the Virginia Department of Health (VDH) to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to me cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me or my child will no longer be protected by this authorization.
- The original or a copy of the authorization shall be included with my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my child's health information to his/her primary care physician and school.
- I understand that this record will be retained for ten years after the last visit or for five years after age 18, whichever comes later. I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third party payer to pay any authorized benefits to VDH on my behalf.

☐ Please check box if you wish to receive a copy of the Virginia Department of Health Privacy Rights.

I understand that the Virginia Department of Health will not release private medical records unless authorized above or to continue care.

____________ Please Print Your Name X____________ Signature ____________ Date

Please send a copy of my child's immunization record to her/his doctor at the following address.

*Doctor's Name*____________ *Mailing Address*____________ *City*____________ *Stat*________ *ZIP*________

HEALTH DEPARTMENT USE ONLY

Date	Item code	Cost type	Lot Number	Vaccine Administration Site			Provider #
		VFC Chargeable		RA	LA	NAS	
		VFC Chargeable		RA	LA	NAS	

Comments

Provider Name/Signature and Date

Instructions on filling out the 2014-15 Student Influenza Consent Form

Please Print Clearly:

Section 1, Page 1

Please make sure your child's name and date of birth are accurate and clearly written.
Please include the name of the responsible parent or Guardian and date of birth of such.

Section 2, Page 1

It is very important that you answer the questions 1-10 accurately. Please double check to make sure all questions are answered.
If you answered YES or left blank any question from #4 through #10 your child WILL NOT receive Flu Mist, but she/he CAN RECEIVE the flu shot at his/her doctor or the Local Health Department.

Section 1, Page 2, Insurance Section

Make sure you have placed a check in one of the insurance section boxes.

If you have checked that your child has Medicaid, Famis or Virginia Premier, write the 12 digit identification number on the line provided as it appears on the insurance card. (Make sure you have 12 numbers listed.)

If your child has Coventry Cares, Optima or Majesta Care or other Medicaid HMO, write the identification number on the line provided, (this number should be between 9-11 digits) and the name of the child as it appears on the insurance card.

If you have checked that your child has another private insurance not listed please include the policy holder's name, date of birth of the policy holder, the insurance identification number of the policy holder as it appears on your insurance card (to include the leading LETTERS) and the Group number. **If possible attach a copy of your insurance card. If not, please be sure to include policy and group numbers.**

PLEASE BE SURE TO SIGN CONSENT IN TWO PLACES ON THIS PAGE.

If the Insurance checked under **other** is a **Participating Insurance** with the Health Department we will make every effort possible to submit your claim and collect from the insurance company. We will accept the insurance reimbursement rates. However, failure of your insurance company to pay or respond to the submitted claim within 60 days may result in the Health Department sending you a onetime statement/invoice in the amount of **$25.00** payable to the Local Health Department within 30 days of receipt of the statement.

If the Insurance checked under **other** is a **Non Participating Insurance** with the Health Department you will receive a onetime statement/invoice in the amount of **$25.00** payable to the Local Health Department within 30 days of receipt of statement/invoice. Once we receive payment, we will gladly assist you if you choose to bill your own insurance for reimbursement.

The Flumist campaign is supported by local (city/county) money, and is only possible through insurance collections and patient payments.