

**DISCARD THIS FORM IF YOU DO NOT WANT YOUR CHILD VACCINATED**

**VACCINATING ALABAMA KIDS IN SCHOOLS**  
(Owned by Huntsville Pediatric Associates)  
**Influenza Vaccine Consent Form**

School \_\_\_\_\_  
Grade \_\_\_\_\_  
Teacher \_\_\_\_\_

**Section 1: Information about student receiving vaccine (Please print)**

STUDENT'S NAME (Last)	(First)	(M.I.)	STUDENT'S DATE OF BIRTH Month _____ Day _____ Year _____
PARENT/LEGAL GUARDIAN'S NAME (if applicable)			STUDENT'S GENDER <u>MALE</u> <u>FEMALE</u>
ADDRESS			PARENT/ GUARDIAN DAYTIME PHONE NUMBER:
CITY	STATE	ZIP	
PATIENT'S PRIMARY DOCTOR'S NAME (Last, First )			

**Section 2: Screening for Vaccine Eligibility**

YES NO

1. Does the patient have a <b>serious</b> allergy to eggs?		
2. Has the patient ever had a serious reaction to a previous dose of flu vaccine?		
3. Has the patient ever had Guillain-Barre` Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

**If you answered yes to any of the above questions, your child is not eligible to receive the flu vaccine at school**

**Section 3: Consent**

I want Fluzone injectable vaccine (shot) <http://www.adph.org/Immunization/Default.asp?id=541>  
(INITIAL)

**The nasal vaccine, FluMist is not available this year**

Signature of Parent/Legal Guardian/Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 4: Insurance Information (this information must be provided for patient to receive vaccine)**

\_\_\_\_\_ My child does not have medical insurance (it is fraudulent to not report medical insurance in an attempt to receive free medical care)

Subscriber's Name: \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_ Policy # \_\_\_\_\_

Group # \_\_\_\_\_ Effective Date \_\_\_\_\_ Name of Insurance \_\_\_\_\_

Signature of Parent/Legal Guardian/Patient \_\_\_\_\_ Date: \_\_\_\_\_

**IF THIS FORM IS NOT COMPLETED IN ITS ENTIRETY, YOUR STUDENT WILL NOT BE VACCINATED.**

If you have any questions, please call 256-265-2464