AURORA CONCEPTS

Seasonal Flu Shot Vaccine Consent Form

Participation in Student Flu Vaccination Program

◯ YES, I wish to participate	◯ NO, I do not wish to participate

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

Insurance Details

Insurance ◯ **CHIP/STAR/Medicaid** ◯ **American Indian/Alaskan Native** ◯

Underinsured (insurance does not cover vaccines) ◯ **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

Yes	No	
◯	◯	1. Is your child 4 years or older?
◯	◯	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)
◯	◯	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.

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.

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

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

VIA CDC IIV		.IIV 0.5 ML IM Injection (Flulaval)		
LOT NUMBER		EXP DATE		
VACCINE MANUFACTURER		TITLE OF VACCINE ADMINSTRATOR		
SIGNATURE		DATE		(RD IM) or (LO IM)