



HealthHUB School Clinic

PO Box 542, South Royalton, VT 05068

Seasonal Influenza Vaccination Consent Form

Student's Name:

Last _____

First _____

Student's Date of Birth _____

Student's Social Security _____

Gender:

Male Female

Student's Race:

- White/Non-Hispanic Black/Non-Hispanic
- Hispanic Asian/Pacific Islander
- Native American/Alaskan Native Unknown
- Other (specify) _____

Student's Address and Phone:

Address _____

City _____

State _____ Zip _____

Primary phone (_____) _____

Parent/Guardian's Address and Phone:

Name _____

Address _____

City _____

State _____ Zip _____

Primary phone (_____) _____

MEDICAL INSURANCE INFORMATION

Policy Guarantor/ Holder/subscriber:

Name: _____

Date of birth _____

Relationship to student: _____

Address _____

City _____

State _____ Zip _____

Primary phone (_____) _____

Primary Insurance: _____

City _____ State _____

Group # _____

Individual # _____

Copay requirements: _____

Secondary Insurance: _____

City _____ State _____

Group # _____

Individual # _____

Copay requirements: _____

FLU VACCINE CONSENT:

1. Does the person to be vaccinated have an allergy to a component of the vaccine (eggs)? Y N
2. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? Y N
3. Has the person to be vaccinated ever had Guillain-Barré syndrome? Y N

By signing this form I am agreeing that I have read the Seasonal Influenza vaccine Fact Sheet. I have answered the questions above to the best of my ability and I am aware of the risks and benefits to my child. I give consent for the Seasonal Influenza Vaccination to be given to my child at the Health Hub Clinic and my insurance to be billed if necessary.

Your signature: _____

Date _____

For clinic use only:

Date of vax: _____

Site: LA RA

Dosage: 0.25 0.5 Lot # _____