KANAWHA-CHARLESTON HEALTH DEPARTMENT
108 Lee Street, East, Charleston WV 25301
2019 Seasonal Influenza Vaccine

****** PLEASE PRINT CLEARLY ******

Student's Name _____
(Last) (First) (Middle)

Current Address _____
(Street Address) (City) (State) (Zip)

Parent/Guardian Phone #s: Home _____ **Cell** _____ **Work** _____

Date of Birth _____ **Age** _____ **Gender** M / F **Race** _____
Month//Day/Year (required)

School Name _____ **Grade** _____ **Teacher/Homeroom** _____

FLU SHOT SCREENING FORM

Please review the Vaccine Information Sheet **BEFORE** completing this form. On the day of the vaccination clinic, If the child is ill with a fever, the nurse may decide to postpone the vaccination. Form must be completed by a parent or legal guardian.

	YES	NO
1. Has your child ever received a Seasonal flu vaccine before? a. If YES, has your child received the shot____ or intranasal____ or both _____ b. If NO, your child has never had a flu vaccine, does he/she have any allergies? Describe_____	☐	☐
2. Did your child have a **reaction** to an Seasonal flu vaccine before? a. If YES, Describe_____	☐	☐
3. Has your child ever been paralyzed with a disease called Guillain-Barré Syndrome (GBS)? a. If YES, Describe _____	☐	☐
4. Does your child have a severe **allergy to eggs**? a. If YES, check with your doctor to see if your child can receive the flu vaccine.	☐	☐
5. Does your child have an **allergy to latex**? a. If YES, Describe _____	☐	☐

School Nurse Signature_____ **Date**_____

PLEASE TURN PAGE OVER AND COMPLETE THE OTHER SIDE

STUDENTS MAY QUALIFY FOR STATE-SUPPLIED VACCINE AT A REDUCED RATE. TO DETERMINE ELIGIBILITY, PLEASE ANSWER THE FOLLOWING:

This child is privately insured **IF YES, PLEASE GO TO INSURANCE INFORMATION** ☐ Yes ☐ No

This child is enrolled in WVCHIP, **IF YES, PLEASE GO TO INSURANCE SECTION** ☐ Yes ☐ No

This child qualifies for Immunization through the VFC Program because he/she (check only one):

- **Does not have health insurance** ☐
- Is an American Indian or Alaskan Native ☐
- Is underinsured (has health insurance that does not pay for vaccinations) ☐

Primary Physician's Name _____
Last name First MI

PLEASE PROVIDE YOUR INSURANCE INFORMATION ** PLEASE PRINT CLEARLY ******

Name of Primary Insurance: _____ **Address** _____

Policy Holder's Name _____ **Relationship To Policy Holder** _____
(Last) (First) (MI)

Policy Holder Date of Birth: _____ **Policy ID #** _____ **Group # (if any)** _____

SECONDARY INSURANCE INFORMATION IF APPLICABLE

Name of Secondary Insurance: _____ **Address** _____

Policy Holder's Name _____ **Relationship To Policy Holder** _____
(Last) (First) (MI)

Policy Holder Date of Birth: _____ **Policy ID #** _____ **Group # (if any)** _____

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

The KCHD Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice of Privacy Practices is subject to change. To obtain a copy of our notice you may visit our website at www.kchdwv.org or by calling (304) 348-8080. By signing this form, you acknowledge that the KCHD Notice of Privacy Practices was made available to you.

CONSENT

You must be at least 18 years of age to sign. If under age 18, a parent or guardian's signature is required. I have read or had explained to me the current Vaccine Information Statement for this Influenza vaccine and understand the risks and benefits. I give consent for my child named at the top of this form to be vaccinated with this vaccine.

Assignment of Insurance Benefits (including Medicare) I request that payment of authorized insurance benefits be made to Kanawha-Charleston Health Department for services furnished to me or my dependent by the Department. Submission of insurance information does not guarantee coverage. I understand that if the insurance company does not cover the vaccine(s), I will be responsible for payment.

_____ _____
Signature of Parent or Legal Guardian Date

Health Department Use Only

VFC_____ KCHD_____

Manufacturer/Vaccine:	*Circle* *GSK*	**Injection Site/Route**	Circle LD or RD	**Date Vaccinated:**	------- / ------- /2019
Lot# Expiration Date:	Place label here	**Nurse Signature:**		_____	