Georgia Department of Public Health
Bryan County
Health Department

Bonzo Reddick, MD, MPH, District Health Director

66 Captain Matthew Freeman Drive, Suite 159
Richmond Hill, GA 31324
Phone: 912-756-2611 | Fax: 912-756-4828

430 Ledford Street, PO Box 9
Pembroke, GA 31321
Phone: 912-653-4331 | Fax: 912-653-4328

Dear Parent/Guardian,

Ensuring the safety of our students from the influenza virus each year is important, and the best way to do that is to get them vaccinated. The Health Department will organize optional flu clinics in schools to assist with this goal. We are dedicated to ensuring a safe and streamlined process for all students, and every enrolled student will have the opportunity to receive the flu vaccine.

Please review the Vaccine Information Statement (VIS) about the flu vaccine. If you would like your student to be vaccinated at the school-based flu vaccination clinic, then you should complete, sign, and return the Parental Consent Form to your child's school as soon as possible. **If this consent form is not filled out completely, signed, dated, and returned before the event date, your student will not be vaccinated at the school-based clinic.** Additional copies of the consent form and VIS are available by going to www.coastalhealthdistrict.org and clicking on the "Immunizations and Vaccinations" link under the Quick Links menu on the home page.

All children are eligible to participate regardless of insurance status. We are asking for insurance information and a copy of your insurance card because we may be able to bill your insurance for the flu vaccine and a small administration fee to help support school-based flu clinics this year and in the future. If your insurance does not agree to pay the fee or you don't have insurance, you will not be billed by us or your insurance.

Please fully answer the medical questions on the consent form. Whether or not your child can receive the vaccine will be determined by the nurse based on your answers to the questions in the Parental Consent Form. If all questions are not answered, then the student will not be vaccinated at the school-based clinic. **It is your responsibility to notify the school and the participating health department at least three business days prior to the school-based flu vaccination clinic event if your child has already received a flu vaccine by another provider this year.**

The flu is easily spread through coughs and sneezes and by touching something with the virus and then touching your eyes, nose, or mouth. The flu vaccine is safe and effective and can help protect your child from illness, hospitalization, or worse.

Thank you, in advance, for helping us keep our students safe and healthy. If you have any questions, please call the Bryan County Health Department at 912-653-4331 (Pembroke) or 912-756-2611 (Richmond Hill).

Sincerely,

Bonzo Reddick, M.D.

Bonzo Reddick, MD, MPH
District Health Director
Coastal Health District

Georgia Department of Public Health
Coastal Health District

Adult Vaccine Consent Form

VHN Code:

Section 1: Information About the Person Who Will Receive Vaccine (please print)

FIRST NAME	MIDDLE	LAST NAME	MAIDEN NAME OF PATIENT'S MOTHER
DATE OF BIRTH (mm/dd/yyyy)	**AGE**	**GENDER** *(Please circle)* Male Female	**SOCIAL SECURITY NUMBER**

ETHNICITY *(Please Check)*
Hispanic/Latino ☐ Yes ☐ No

RACE *(Please Check)*
☐ African American/Black ☐ White ☐ Hispanic or Latino American ☐ American Indian
☐ Asian ☐ Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other

HOME ADDRESS **PHONE NUMBER**

CITY **STATE** **ZIP CODE**

INSURANCE INFORMATION
☐ No Insurance ☐ Insurance
Please attach a copy of the insurance card to this form.

Name of Policy Holder/Name on ID Card: _____

Member ID# _____ Group# _____

Section 2: Medical Information – The following questions will help us to determine if you can receive the vaccine.

**Please circle Yes, No, or I Don't Know (IDK) for every question.*

1. Are you sick today?	Yes	No	IDK
2. Do you have allergies to medications, food, a vaccine component, or latex?	Yes	No	IDK
3. Have you ever had a serious reaction after receiving a vaccine?	Yes	No	IDK
4. Do you have any of the following: a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	Yes	No	IDK
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problems?	Yes	No	IDK
6. Do you have a parent, brother, or sister with an immune system problem?	Yes	No	IDK
7. In the past 6 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	Yes	No	IDK
8. Have you had a seizure or a brain or other nervous system problem?	Yes	No	IDK
9. Have you ever been diagnosed with a heart condition (myocarditis or pericarditis) or have you had Multisystem Inflammatory Syndrome (MIS-A or MIS-C) after an infection with the virus that causes COVID-19?	Yes	No	IDK
10. In the past year, have you received immune (gamma) globulin, blood/blood products, or an antiviral drug?	Yes	No	IDK
11. Are you pregnant?	Yes	No	IDK
12. Have you received any vaccinations in the past 4 weeks?	Yes	No	IDK
13. Have you ever felt dizzy or faint before, during, or after a shot?	Yes	No	IDK

Section 3: Consent to vaccinate:

CONSENT TO RECEIVE VACCINE

By signing below, I acknowledge that the medical information provided above is correct. I have been given a copy of the VACCINE INFORMATION STATEMENT. I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the vaccine.

Signature of Patient: _____ **Date:** _____

FOR CLINIC USE ONLY

Record of Immunization

VACCINE	MFR.	LOT #	EXP.	DOSAGE	ROUTE	SITE	VIS	NURSE

Nurse Signature: _____ **Date:** _____ **Entry Clerk Initial:** _____ **Date:** _____

Date of Vaccination: _____

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