North Little Rock School District

2400 Willow Street • North Little Rock, Arkansas 72114 • (501) 771-8000 • www.nlrsd.org

Influenza

In compliance with the Family Education Right to Privacy Act (FERPA) (20 U.S.C.§ 1232g; 34 CFR Part 99),

I give permission for my child _____, _____, to participate in
First and Last Name DOB

the Influenza Vaccine Clinic.

Parent/Guardian Signature _____

Date _____

Influenza (spanish)

En cumplimiento con la Ley de Derechos de la Familia sobre la Educación y Privacidad (FERPA siglas en inglés) (20 U.S.C. § 1232g; 34 CFR Parte 99)

Yo, _____, doy permiso para que mi hijo, _____.
Nombre de Padre/Tutor

Nombre y Apellido participe en la Clínica de Vacunación Escolar contra la Influenza.

Firma del Padre/Tutor _____

Fecha _____

ARKANSAS DEPARTMENT OF HEALTH (ADH)
INFLUENZA SEASON - IMMUNIZATION CONSENT FORM

FOR ADH USE ONLY
ADH Clinic Code: _____ Date of Service: _____ AASIS Number: _____
School Name: _____ Grade: _____ LEA Number: _____

1- Person Receiving Vaccine:

Legal First Name: _____ MI: ____ Last Name: _____

Date of Birth: _____ Sex: Male ☐ Female ☐ Age: _____

Telephone Number: _____

Street Address: _____ P.O. Box: _____ Apt Number: _____

City: _____ State: _____ Zip Code: _____

Race:
American Indian / Alaskan Native ☐ Black / African American ☐
Native Hawaiian / Other Pacific Islander ☐ Asian ☐ White ☐

Ethnicity:
Hispanic / Latino ☐
Non-Hispanic / Latino ☐

Insurance Status:

Insurance Company Name: _____ Member ID/ Policy Number: _____

Relationship with the Policy Holder: Self ☐ Spouse ☐ Other ☐ (If you are the policy holder, you are not required to complete the section below.)

Policy Holder Information:

Legal First Name: _____ MI: ____ Last Name: _____

Date of Birth: _____

2- Release & Assignment: Visit the website Current VISs | Vaccines & Immunizations | CDC **to read the current influenza Vaccine Information Statement.**

- I have read or had explained to me the Vaccine Information Statement for the Inactivated Influenza Vaccine and I understand the risks and benefits.
- I give consent to ADH to vaccinate the individual named above with the flu vaccine.
- I acknowledge reviewing the ADH Privacy Notice at www.healthy.arkansas.gov, the clinic site, or with this form.
- I understand the vaccination information will be included in the ADH Immunization Registry.

To my Insurance Carrier(s):

- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to the ADH.
- I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.
- I agree that a photocopy of this form may be used instead of the original.
- My signature below indicates I agree to Section 2- Release and Assignment.

Signature of Patient/ Parent/Guardian: _____ **Date:** _____

3- Medical History: Complete the following questions for the person receiving the flu vaccine.

For ADH staff: If YES is checked and further guidance is needed, notify the Regional CDNS	Yes	No
1. Do you have a fever today? (If you have fever on the day of the clinic, it may prevent you from receiving the flu vaccine.)	☐	☐
2. Have you ever had Guillain-Barré Syndrome (temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐
3. Have you ever had a serious reaction to a flu vaccine such as difficulty breathing, swelling of eyes or lips, wheezing, or immediate nausea or vomiting?	☐	☐
4. Do you have a severe allergy to any flu vaccine component, food, or medication? (i.e., gelatin, gentamicin, or neomycin)	☐	☐
5. Have you ever felt dizzy or faint before, during, or after a shot?	☐	☐
6. Are you anxious about getting a shot today?	☐	☐
7. Are you pregnant today?	☐	☐
8. If pregnant, are you receiving prenatal care?	☐	☐

For School Clinic Use: Child's Homeroom Teacher _____

Note:
Children aged 6 months through 8 years may require a second dose. Contact your health provider or your ADH Local Health Unit in four weeks for more information.

Flu Vaccine Administration: To be completed by ADH staff only

Shot Code: 70:Trivalent (P-F) ≥ 6 months ☐ 72: Trivalent (P-F) ≥ 65 years ☐

Flu Vaccine: Route IM: ☐

Site Code: _____ Dosage mL: _____ MFG Code: _____ Lot Number: _____

Site Codes		MFG Codes	
Right Deltoid (**RD**)	Right Leg (**RL**)	GlaxoSmithKline (**SKB**)	Sanofi (**PMC**)
Left Deltoid (**LD**)	Left Leg (**LL**)	MedImmune (**MED**)	Seqirus (**SEQ**)

Signature Vaccine Administrator/Title: _____ **Date Vaccine Administered:** _____