SCHOOL FLU VACCINATION REGISTRATION

Child's Legal First Name:	Child's Legal Last Name:	Sex:	Child's Date of Birth:
School/Grade:	Email Address:		
Address:	City:	State:	Zip:
Doctor:	Home Phone:	Cell Phone:	

Consent to Vaccinate: By signing below I confirm that I have read the information that is contained in the Vaccine Information Sheets that have been provided. I confirm that I have had a chance to ask questions and fully understand the benefits and risks of the vaccines I have consented to. I request that these vaccines be given to individual named at the top of this page.

Release of Information: I authorize DCMH staff to release information required by third-party providers for the sole purpose of payment. I also agree to the release of information to the Children and Hoosier Immunization Registry Program (CHIRP). All HIPAA privacy practices apply, the same as the DCMH Immunization Clinic. Financial Responsibility: I acknowledge and agree that by signing I am legally responsible for this account and collection of said account.

Release: I knowingly and voluntarily assume all risks associated with my child's receipt of an immunization. I hereby release DCMH, its directors, officers, physicians, employees, and agents from any and all liability or claim for damage arising from said vaccinations. I also acknowledge that no guarantees have been made to me as to the results of an immunization and should always consult a physician for questions.

Consent for use of Health Information: I understand that as part of my child's healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

CONSENT TO RECEIVE INFLUENZA (FLU) VACCINE

I have read the "Influenza Vaccine: What You Need to Know" (Inactivated Influenza Vaccine 8/15/19). I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine and have consented to my child receiving the vaccine.

1. **YES or NO Is your child allergic to eggs or neomycin and have they ever had Guillain-Barré syndrome?**
2. **YES or NO Has your child ever had a severe reaction to the flu vaccine?**

Signature of Parent/Guardian:	Date:
Printed Name of Parent/Guardian:	Relationship to Child:

FOR HOSPITAL USE ONLY:

Date Flu Vaccine Given: ____________________

Manufacturer: GSK or Sanofi
Lot: _____________
Expiration: ________

Site: Lt. Deltoid Rt. Deltoid

Or place sticker here

Given By: _________________________

IC-015-X
Approved: 08/23/2019
Reviewed: 08/23/2019