Cass Health

Student Influenza Vaccination Consent

I have received and read the Centers for Disease Control's Influenza Vaccine Information Statement. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine and ask the vaccine to be given to me or the person named below for whom I am authorized to make this request. I understand Cass Health will bill the insurance coverage provided below, and I am responsible for and will receive a statement for any amount that my insurance does not cover.
I understand that not filling out this form completely, clearly, and correctly may cause incorrect vaccination or billing.

Parent/Guardian Signature _____ Date _____

STUDENT/PATIENT NAME (LAST)	(FIRST)	BIRTHDATE / /	SCHOOL _____ GRADE _____
HOME ADDRESS	CITY, STATE, ZIP	STUDENT AGE	GENDER ☐ MALE ☐ FEMALE
PARENT/GUARDIAN PRINTED NAME		PARENT/GUARDIAN DAYTIME PHONE	
INFLUENZA VACCINE CHOICES Which vaccine do you want for your child?	☐ FLUMIST Administered via nasal spray	☐ FLU SHOT Administered via injection	

Please answer the following questions to receive your flu vaccination – if you answer "YES" to one or more questions a nurse will contact you to discuss your options.	NO	YES
1. Does this student have a serious allergy to eggs?		
2. Does this student have any other serious allergies? LIST:		
3. Has this student ever had a serious reaction to a previous dose of flu vaccine?		
4. Has this student ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) occur within 6 weeks of receiving flu vaccine?		
5. Has this student received any vaccinations within the past 30 days? IF YES -Please provide date and type of vaccine:		
6. Does this student have any of the following: asthma, diabetes (or any other metabolic disease), or disease of lungs, heart, kidneys, liver, nerves, or blood?		
7. Is this student on long-term aspirin or aspirin-containing therapy? (Do they take aspirin every day?)		
8. Does this student have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those to treat cancer)?		
9. Is this student pregnant?		
10. Does this student have close contact with a person who needs care in a protective environment (for example, someone who has recently had a bone marrow transplant)?		

Payment Method

- ☐ I have Medicaid, no insurance, or my insurance does not cover immunizations. (Vaccine provided at no cost.)
- ☐ I am American Indian or Alaskan Native. (Vaccine provided at no cost.)
- ☐ I have private/commercial insurance and want the bill submitted through my insurance plan.
  ** Use the information on your insurance card to complete information below or attach a copy of your insurance card.**

Insurance Information	Insurance Policy Holder's Information
☐ No insurance ☐ Medicaid _____ ☐ Hawk-I ☐ I have private/commercial insurance. Insurance Company _____ Please complete information at right.	Name _____ Birthdate _____ Address _____ City, State, Zip _____ Insurance Policy/Member Number _____ AND/OR Group Number _____

For Office Use Only

Form reviewed by _____ Date _____ VFC | Private