



School: _____

HealthHUB School Clinic

PO Box 542, South Royalton, VT 05068

Seasonal Influenza Vaccination Consent Form '20-'21

If child is already a South Royalton Health Center patient, **only** complete Sections 1 & 3

SECTION 1

Student's / Participant's Information:

Last Name _____

First Name _____

Student's Date of Birth _____

Student's Social Security # _____

Regular Primary Care Provider _____

Gender: Male Female

SECTION 2

Student's / Participant's Address and Phone:

Address _____

City _____

State _____ Zip _____

Primary phone (_____) _____

Regular Pediatrician _____

Parent's Address and Phone (if different from above):

Name _____

Address _____

City _____

State _____ Zip _____

Primary phone (_____) _____

MEDICAL INSURANCE INFORMATION

Policy Guarantor/ Holder/subscriber:

Name: _____

Date of birth _____

Relationship to student: _____

Address _____

City _____

State _____ Zip _____

Primary phone (_____) _____

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For clinic use only:

Date of vax: _____

Site: LA RA

Dosage: 0.25 0.5 Lot # _____

Form updated 9/7/20, Gnaedinger

Primary Insurance: _____

City _____ State _____

Group # _____

Individual # _____

Copay requirements: _____

Secondary Insurance: _____

City _____ State _____

Group # _____

Individual # _____

Copay requirements: _____

Student's / Participant's Race:

White/Non-Hispanic Black/Non-Hispanic

Hispanic Asian/Pacific Islander

Native American/Alaskan Native Unknown

Other (specify) _____

Prefer not to answer

SECTION 3

FLU VACCINE CONSENT:

1. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? Y N

2. Has the person to be vaccinated ever had Guillain-Barré syndrome? Y N

By signing this form I am agreeing that I have read the Seasonal Influenza vaccine Fact Sheet. I have answered the questions above to the best of my ability and I am aware of the risks and benefits to my child or myself. I give consent for the Seasonal Influenza Vaccination to be given to my child or myself at the HealthHUB School Clinic and my insurance to be billed.

Your signature: _____

Date _____

Email _____

Return completed form to school nurse/secretary.