HealthHUB School Clinic

PO Box 542, South Royalton, VT 05068

Seasonal Influenza Vaccination Consent Form

Student's Name:
Last ______________________________
First ______________________________
Student's Date of Birth ______________________________
Student's Social Security ______________________________

Gender:
☐ Male ☐ Female

Student's Race:
☐ White/Non-Hispanic ☐ Black/Non-Hispanic
☐ Hispanic ☐ Asian/Pacific Islander
☐ Native American/Alaskan Native ☐ Unknown
☐ Other (specify) ______________________________

Student's Address and Phone:
Address ______________________________
City ______________________________
State ______________ Zip ______________
Primary phone (_____) ______________________________

Parent/Guardian's Address and Phone:
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 (_____) ______________________________

Primary Insurance: ______________________________
City ______________ State ______________
Group # ______________________________
Individual # ______________________________
Copay requirements: ______________________________

Secondary Insurance: ______________________________
City ______________ State ______________
Group # ______________________________
Individual # ______________________________
Copay requirements: ______________________________

FLU VACCINE CONSENT:

1. Does the person to be vaccinated have an allergy to a component of the vaccine (eggs)? ☐ Y ☐ N
2. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? ☐ Y ☐ N
3. 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. I give consent for the Seasonal Influenza Vaccination to be given to my child at the Health Hub Clinic and my insurance to be billed if necessary.

Your signature: ______________________________

Date ______________________________

Email ______________________________

For clinic use only:
Date of vax: ______________________________
Site: ☐ LA ☐ RA
Dosage: ☐ 0.25 ☐ 0.5 Lot # ______________