

Healthy Kids Clinic Toll Free: 844-435-0900 FLU SHOT CONSENT FORM

*Only Complete If You Wish For Your Student To Receive An Influenza Vaccine*A District Wide "All Call" Will Be Sent Out To Parents Notifying You Of The School Districts Flu Clinic Dates

Dear Parent/Guardian,

The Healthy Kids Clinic will have influenza (flu) vaccinations available to students during the flu season months. Please sign below if you give permission for your child to receive the flu vaccine on the day our provider and nurse visit your child's school. Please note, the Center for Disease Control (CDC) recommends that children six months and older receive the Influenza vaccine annually.

older receive the initia	Chiza vaccine anne	adily.				
Student Name:		Sex Assigned At	Birth :	Allergies:		
School Name:		Homeroom:		Birthdate:		
Address:				Zip Code:		
Phone Number:		Social Se	Social Security Number:			
Insurance Compan	y:	Policy Number:		Group Number:		
Policy Holder Name):	DOB:	Rela	tionship To Patient:		
Address Of Policy H	lolder If Different	t Than Patient:				
Language:	Race:	Race:Hispanic/Non-Hispanic:				
		scle. Some conditions are lestions regarding your chil		s or contraindications to receive this		
 Does your child have □No *If you answer yes to child's primary care 	e a history of Guilla o any of the above provider to deter	e questions, we encoura	6 weeks for ge you to a appropria	schedule an appointment with your ate for them to receive; If your child		
influenza vaccine give	en by the Healthy k	Kids Clinic in the student's	school. I ur	ermission for this student to receive the nderstand that that if I take my student to ol nurse know immediately.		
Parent/Guardian	Name (Printed	d):				
Parent/Guardian Signature:			Date:			
	If Your Child	Is Eight Years or Your	nger, Plea	ase See Below		
trivalent or quadrivale vaccine separated meets the above crit	nt influenza vaccin by 4 weeks for ma eria, we can offer b	ne greater than 4 weeks ap aximum protection. If your	oart before on the child is 6 m Kids Clinic.	have not previously received 2 doses of July 1, 2022, receive two doses of the flunonths through eight years of age and By initialing below, you as the parent or onfluenza vaccine series.		

Please Initial by Vaccine: _____Two-Part Flu INJECTION

Office Use Only:							
Lot #: Date & Time Given	Exp. Date	Manufac	turer				
VS : (T)(P)	(O2 sat)	Nurses Name:	Inj. Site:				