Vaccine Administration Parental Consent Form

FOODLAND PHARMACY #26

Student's Name (Last, First, MI)	Gender: □ Male □ Female	Date of Birth (MM/DD/YYYY):
Parent/Legal Guardian Name:	Parent/Legal Guardian Phone #:	School Name: KEAAU HIGH SCHOOL
Home Address:	City, Zip Code:	Student Grade:
Student's Pediatrician/PCP:	Student's Pediatrician/PCP Phone #:	Student's Type of Insurance:
Student's Insurance **Subscriber ID #:**	Insurance **Subscriber's Name:**	Insurance **Subscriber's DOB:**

Please answer the following questions:	**YES**	**NO**	**Don't Know/ Not Applicable**
Does your child have an egg allergy?			
Does your child have an allergy to gentamicin, neomycin, polymixin, latex, medications or vaccines?			
Has your child ever had a serious reaction to any vaccine?			
Does your child have a history of Guillain-Barre Syndrome within 6 weeks of receiving a flu vaccine?			

***Please list all of your child's allergies**:_____

Parent/Legal Guardian Consent and Waiver

Consent for student's vaccination: I have read and/or had explained to me the 2021-2022 Vaccine Information Statement for the influenza vaccine and understand the risks and benefits. By signing below, **I □ DO □ DO NOT GIVE CONSENT** for my child named at the top of this form to get vaccinated with this vaccine. (If this consent is not signed, dated and returned, my child will not be vaccinated).

Permission to Share Information: Complete this section if you consented to have your child receive the flu vaccine. This information will be shared to ensure that your child is appropriately vaccinated. You may refuse to sign this authorization to share information. Refusal to sign will not affect your child's ability to obtain the vaccine.

I, _____, give permission to the individual and/or entity
(Print Your Name)

that administered the 2021-2022 influenza vaccine to my child, _____ to
(Print Child's Name)

Share copies of the 2021-2022 flu vaccine consent form and vaccination record with my child's school and health care provider named below, as well as with the Hawaii Department of Public Health and local board of health in my community.

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated
- This permission expires at the end of the 2021-2022 school year
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the Hawaii Department of Public Health and local boards of health.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time.
- However if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.

I have read, or had explained to me, the Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose.

Signature of Parent/Legal Guardian:	Printed Name of Parent/Legal Guardian:	Date:

To Be Completed By Immunizer

Vaccine	Dose	Manufacturer	Route and Site	Lot Number	Expiration Date
FLUCELVAX	0.5mL	*SEQIRUS*	IM □ Right □ Left	308477	6/30/22

Vaccinator's Signature:	Date: