Unity Health and Wellness, LLC

For the health of all of our students, faculty, and your family, we encourage you to obtain a flu vaccination for your child through our voluntary clinic, your local healthcare provider or pediatrician. For questions please email: Lora@unitywellness.org

STUDENT INFORMATION: Reminder you must **complete both sides of this form in full.** Please PRINT neatly using blue or black ink.

First Name			Middle Initial	Last Name		
Child DOB (MM/DD/YY)	AGE	Gender (M/F)	Name of School		Home Room Teacher	Grade
Student Race Please Circle	White	African American	Amer. Indian/ Alsk. Native	Hispanic	Asian	Other

Authorizing Parent or Guardian Information: Please PRINT neatly using blue or black ink.

First Name	Last Name	Relationship to this child
Address	City	State / Zip
Parent or Guardian Emergency Contact #	Child's Primary Physician & Phone	
We will never sell or share your email address. We ask for it only to communicate information regarding clinics.	Email Address	

Required Medical Insurance Information: **(Please circle one)**

BCBS	United Health Care	CIGNA	Aetna	Other—List Name
Cardholder name		Cardholder birth (MM/DD/YY)	Medicaid or Medicaid HMO	
Contract or Member ID		Group ID	If Medicaid/Medicaid HMO list **CHILD'S** Medicaid number	

☐ NO INSURANCE

Authorization: By signing below, I consent to the use and disclosure of my child's personal health information for the purpose of health care operations, along with the assignment of all payments from issuer above to Unity Health and Wellness, LLC for the services rendered.

Consent: I consent for my child to receive the seasonal influenza vaccine at school. I am aware that I can locate the most current Vaccine Information Statement and other information on www.immunize.org or www.cdc.gov. I have read the Vaccine Information Statement. I have had the opportunity to ask questions about the vaccine. I understand the benefits and risks of the vaccine. I have read and answered the questions on the medical and health screening accurately. I understand that incorrect information could cause serious risks to my child. I am aware that the receiver of this vaccine is currently not pregnant and should not become pregnant within four weeks of receiving this vaccine. I request and voluntarily consent for the vaccine to be given to the student/child above of whom I am the parent or legal guardian and acknowledge no guarantees have been made concerning the vaccines success. I hereby release the school system, Unity Health and Wellness, LLC, their directors, or employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date.

Parent or Guardian Signature _____ Date _____

HEALTH SCREENING:

The following questions will help us determine if there is any reason that we should not give your child a seasonal influenza vaccination. If a question is not clear, please ask your healthcare provider to explain it.

All questions must be answered for your child to be immunized

1	Has this child has been diagnosed with Asthma? (If NO, go to question #2)	YES	NO
	Has the inhaler been used in the last week?	YES	NO
	Has the inhaler been used one or more times in the last month?	YES	NO
	Has your child received the influenza nasal mist in the past?	YES	NO
2	Has this child ever had a severe or life threatening allergic reaction to the flu vaccine?	YES	NO
3	Does this child have any of the following:		
	Diabetes or other metabolic disorders	YES	NO
	Heart disease or disorders	YES	NO
	Kidney disease or disorders	YES	NO
	Blood disease or disorders	YES	NO
4	Is this child allergic to vaccine components such as: eggs, gentamicin sulfate, or MSG?	YES	NO
5	Is this child pregnant or nursing?	YES	NO
6	Has this child ever had Guillain-Barre syndrome?	YES	NO
7	Is this child on long term aspirin therapy?	YES	NO
8	Does this child live with or expect to have close contact with a person whose immune system is severely compromised and must be in a protective isolation environment?	YES	NO
9	Does this child take medications that lower the body's resistance to infection?	YES	NO
10	Has this child received a MMR or Varicella vaccine in the last 30 days?	YES	NO

PLEASE ANSWER EACH QUESTION PLEASE ANSWER EACH QUESTION PLEASE ANSWER EACH QUESTION PLEASE ANSWER EACH QUESTION

If you answered YES to any of the <u>ABOVE</u> questions you may be contacted by our medical staff to determine if your child should be immunized by your regular health care provider and not in the school setting.

Your child's safety is our primary concern.

Additional questions

A	Is this the first time this child will be vaccinated for the flu?	YES	NO
B	Was this child flu vaccinated for the first time last year? If yes, how many doses?	YES	NO
C	Has this child received any other vaccinations in the past 4 weeks? If yes, list vaccination(s)?	YES	NO

---------- For Clinic Use Only----------

MFR Lot & Expiration Date:

Private VFC State

LAIV Intranasal

IIV3 IIV4 RD LD

RN: _____ Date of Clinic: _____

VIS CDC LAIV 8/19/2014

Administrative Use Only: (Date/Initial)

Filed: _____

CARES :_____

Other: _____