2024-2025 Seasonal Flu Mist Vaccine Consent Form
THIS FORM MUST BE RETURNED

PLEASE COMPLETE THE INFORMATION BELOW (Unreadable and incomplete forms may not be accepted.)

Full, Legal Name of Student *(First Name Middle Initial. Last Name)* **PLEASE PRINT**		**Name of School**	
Parent/Guardian Name *(First Name Middle Initial. Last Name)*	**Relationship to Student**	**Homeroom Teacher**	**Grade**
Street Address	**Email Address**	**Birth Date** (month/date/year)	**Age** **Sex**
City:	**Zip Code**	**Home Phone #**	**Cell Phone #**

Demographic Information: (Circle one) White American Indian/Native Alaskan Black Asian Hispanic Other

☐ **INSURANCE** ☐ **MEDICAID (Prestige, UHC Community, StayWell/Wellcare, & Sunshine)** ☐ **MY CHILD DOES NOT HAVE HEALTH INSURANCE**

The current health care laws require us to bill your insurance company for the vaccine. You will not be billed, and there will be no co-pay or deductible due. The service is offered at no cost to you! As always, answers are confidential. Please fill out the following questions regarding your child's health insurance plan:

Insurance Company/Medicaid Plan	Member ID:
Policy Holder's Name:	Policy Holder's Date of Birth:

HEALTH QUESTIONS: CHECK YES OR NO FOR EACH QUESTION

Yes	No	
☐	☐	**1. Do any of the following apply to your child?** ***(If you answer YES, your child cannot receive FluMist unless approved by your child's doctor)*** • **Allergy to gelatin, chicken eggs or egg products** • **Life threatening reaction(s) to flu vaccine in the past** • **Currently receiving aspirin or aspirin-containing therapy** • **Currently has active asthma (regularly taking asthma medication)** • **Has had Guillain-Barre syndrome (very rare)** • **Is pregnant or nursing/breastfeeding** • **Has HIV/AIDS or cancer or has received an organ transplant** • **Has long-term health problems with weakened immune system, heart disease, lung disease (e.g. cystic fibrosis), liver disease, kidney disease, or metabolic disorders (e.g. diabetes) or blood disorders (e.g. sickle disease or thalassemia)** • **Has other severe chronic health conditions**
☐	☐	**2. Will your child have close contact with a person with a severely weakened immune system?** *(For example, a protective sterile hospital environment for bone marrow transplant)*
☐	☐	**3. Between July. 2024. and Dec. 2024, has/will your child receive one of the following vaccines: MMR, MMRV, and/or Chicken pox vaccine (VZV)?**

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S HEALTH CARE PROVIDER OR CALL THE ALACHUA COUNTY HEALTH DEPARTMENT TO SPEAK WITH A NURSE AT; 352-334-7950

I have received, read, and understand the CDC Vaccine Information Statement for the live attenuated intranasal flu vaccine (FluMist) and the Notice of Privacy Practices. I have read these documents and understand the risk and benefits of the FluMist vaccine. I give permission to the State of Florida, Department of Health to give my child the vaccine in my absence, to communicate with other healthcare providers, as needed, and for data entry, billing and storage according to Florida Department of Health policies, to assure optimal healthcare for my child.

☐ **YES, I Want To Help Protect My Child, Family And Community From Flu By Allowing My Child To Receive FluMist!**

☐ NO, I do not want my child to receive the FluMist Vaccine at school, because _____
(Optional)

_____	_____	_____
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

MedImmune (MED)
FluMist, Intranasal (NAS), 0.2ml
VIS: 08/06/2021

Vaccine Lot # & Expiration Date Label

Date Given: _____

Signature/Title _____

Nurse/clinic notes;

Notes:

Please return to the school, FAX to (352) 334-7947, or EMAIL to; SLIV@flhealth.gov
(Please note that e-mailing may not be a secure method of communication)