2026-2027 Seasonal Flu Shot Vaccine Consent Form

QUESTIONS: CIRCLE YES OR NO FOR EACH QUESTION

1. Is your child 4 years or older? YES NO
2. Do any of the following apply to your child? YES NO

- Allergy to chicken eggs or egg products
- Life threatening reaction(s) to flu vaccine in the past
- Allergy to latex
- Has had Guillain-Barre syndrome(very rare)

(If you answer YES, your child cannot receive a Flu Vaccine at school, please contact your child's doctor)

3. Do any of the below apply to your child? YES NO
   - 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)
     IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL FLORIDA DEPARTMENT OF HEALTH-FLAGLER COUNTY AT (386)437-7350 EXT 7069

_____ _____ _____ _____ _____
Child's Last Name | Child's First Name | Date of Birth | RACE | SEX

_____ _____ _____ _____ _____
Address | City | State | Zip | Phone / Contact #

_____ _____
Name of School | Homeroom Teacher/Grade

If possible, attach a copy of your CHILD's Insurance Card front and back.

CHILD's Insurance Company Name_____ **Medicaid ID or #**_____
CHILD's Insurance CLAIMS Address *(located on your insurance card):*
_____
CHILD's Insurance Company Phone Number:_____
CHILD's Insurance Group #:_____ **CHILD's Insurance Member ID Number:** _____

PARENTS / GUARDIANS:

I, _____ have the following relationship with the person named above, and have the legal authority
(Print name of consenting adult) pursuant to s.743.0645, F.S., to consent to this vaccine administration.

____ Father ____ Stepfather ____ Grandfather ____Adult Brother ____Adult Uncle _____ Court Order
____ Mother ____Stepmother ____Grandmother ____Adult Sister ____Adult Aunt _____ Legal Guardian

I have received and read the CDC Vaccine Information Statement for the Inactivated Influenza Vaccine 01/31/2025 and I understand the benefits and risks. By signing this consent, I am authorizing the FDOH-Flagler County Staff to administer the Inactivate Influenza Vaccine to the person designated on this form ***in my absence***. I also understand that by my signature below I acknowledge receipt of the notice of privacy rights, and if applicable, I assign the benefits for services to FDOH-Flagler County and authorize FDOH-Flagler County to submit a claim to my insurance company for payment on my behalf. If my insurance denies the claim, I understand I will not be responsible for payment of this service.

Printed Name of consenting adult: _____ **Signature of consenting adult:** _____ **Date:** _____

This form is DUE BACK BY SEPTEMBER 14, 2026 FORM REVIEW (INITIALS) / DATE:

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

Manufacturer: _____ **Lot #**_____ **Exp. Date:** _____

Route: _____ IM **Site:** _____RD _____LD

Administered by(initials)**:**_____ **Title** _____ **Date:** _____