Cedar Rapids Community School District
Every Learner. Future Ready.

Influenza Vaccine Consent Form

Last Name	First Name	Middle Name
Birthdate	Race	Gender
School	Grade	Age (must be </=18)
Parent/Guardian Name	Phone	
Address	City	
Physician	Insurance	Medicaid #

Does your child have any allergies to any food or medicine: Yes No
If yes, please list all allergies: _____
Have you ever been told your child has asthma or any other breathing problem: Yes No
Is this the first time your child has ever received a flu vaccine? Yes No
Children younger than 9 years of age receiving influenza vaccine for the first time should get 2 doses, given at least one month apart.
Are you pregnant? Yes No
Are you currently sick with a moderate to severe illness (e.g.fever)? Yes No
Have you taken Tamiflu, Relenza, Amantadine, Rimantadine (flu medication) in the past 48 hours? Yes No
Do you have any of the following illnesses? Asthma, chronic lung disease, chronic heart disease, diabetes, kidney dysfunction? If so, please indicate which one _____
Do you have an immune deficiency? For example, do you have an immune system disease or do you take immunosuppressive medication? Yes No
Have you ever been diagnosed with Guillain-Barre Syndrome (GBS) , a paralyzing nerve disease? Yes No
Have you ever had a life threatening reaction to the flu vaccine? Yes No
Have you ever had a serious reaction to eggs? Yes No

Consent for 2022-23 Influenza Vaccine

I have been given a copy and understand the Inactivated Influenza Vaccine Information Sheet dated 8/6/21. I was given a chance to ask questions and my questions were answered to my satisfaction. I understand the benefits and risks of the Influenza vaccine. I authorize Metro Care Connection (Cedar Rapids Community School District's school-based health center) to provide the person named above the 2022-23 Influenza vaccine.

Electronic Health Record Notice

I understand that my child's Metro Care Connection health visits will be a part of the MercyCare Service Corporation (MSC) EPIC Electronic Health Record System. Because my child has a medical record within the MercyCare Service Corporation (MSC) EPIC Electronic Health Record System I understand that my child's record may be viewed by MercyCare Service Corporation health care employees and in some situations could be viewed by other healthcare providers outside of Mercy through the EPIC Care Everywhere connection and by signing below I consent to any disclosure consistent with this paragraph.

Privacy Notices

I acknowledge that I have had opportunity to read/receive Metro Care Connection's FERPA Notice of Rights and HIPAA Notice of Privacy Practices. A copy of the full disclosure can be obtained in one of our MCC clinics.

Parent/Guardian Signature _____ **Date** _____

This vaccination program is offered **free** of charge to those Cedar Rapids Community School District students **age 18 and under** who qualify. For data purposes, please circle the line below that applies to your child:

- Is enrolled in Medicaid (Title 19)
- Does **not** have health insurance
- Is American Indian or Alaskan Native
- Has health insurance that does not pay 100% for vaccine

For office use only:

Date	Site	Manufacturer/Lot #	Nurse Signature
	L deltoid/ R deltoid		