AUTHORIZATION AND CONSENT

By signing below, I consent to the use and disclosure of my [illegible] personal health information for public health purposes and program evaluation. [illegible] Privacy Notice can be found at the following link: http://www.scdhec.gov/sites/default/files/Library/ML-025046.pdf or a copy of the notice will be provided upon request.

If applicable, by signing below, I request that payment of Medicaid benefits be made on my behalf to [illegible], for any services provided to my child. I give [illegible], [illegible] [illegible]ters for Medicare and Medicaid Services (CMS), its agents, or other agents needed to determine benefits related to services provided. I agree to participate in treatment plans and to assignment of Medicaid benefits to [illegible], for services rendered.

Vaccine Authorization: I voluntarily request DPH to provide seasonal influenza vaccine for my child named above, and consent for my child to receive the seasonal influenza vaccine at school, to be administered by DPH staff. I have read and answered the questions on the previous page carefully and accurately, and I understand that incorrect information could cause serious risks to my child. I understand that the vaccine will be given according to Advisory Committee on Immunization Practices (ACIP) recommendations and the answers I provided to the screening questions 1-10 on the previous page. I have read the Vaccine Information Statement for the flu vaccines: Flu Shot: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf or Nasal Spray: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flulive.pdf. I have had an opportunity to ask questions about the vaccine. I understand the risks and benefits of the vaccine. I consent to my [illegible] testing by DPH should there be an occupational exposure during the administration of the influenza vaccine and DPH deems such testing necessary.

I understand that immunization information about my child will be reported to SC Immunization Registry for public health purposes. I understand this consent is valid for sixty (60) days from the date of my signature. I also understand it is my responsibility to notify the school nurse in the event I change my mind after giving consent or if my child r[illegible] any change s to my child's health, resulting in a change to any of my responses to the questionnaire. I have legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.

SIGNATURE OF PARENT OR LEGAL GUARDIAN		**DATE** / /

VACCINATION DETAILS (Influenza V04.81) FOR CLINIC USE ONLY – BLACK INK ONLY

VACCINE □ IIV4 ☐ LAIV	**ELIGIBILITY** ☐ VFC MEDICAID ☐ VFC AMERICAN INDIAN/ALASKA NATIVE ☐ VFC UNINSURED (NO INSURANCE) ☐ STATE UNDERINSURED ☐ STATE INSURED	
VIS DATE 08/06/2021	**MANUFACTURER:** □ GLAXOSMITHKLINE ☐ ASTRA ZENECA ☐ SANOFI PASTEUR **LOT NUMBER**	**SITE OF ADMINISTRATION** □ LD ☐ RD ☐ NASAL ☐ Other ____________
NURSE	Nurse: I hereby attest by signature below that the patient (or guardian of patient) in question has been given the Influenza Vaccine Information Sheets and has given written consents for vaccination.	**DATE** / / **ECODE** | **COUNTY CODE**
HOMEROOM TEACHER/SCHOOL DESIGNEE SIGNATURE	Teacher/School Designee: I hereby attest by signature that the identity of the patient in question has been verified.	**DATE** / /

☐ [illegible] to Know [illegible] given to student
☐ Unable to vaccinate due to ___________________ [illegible]Unable to s[illegible] form given to student/school

☐ 1st influenza dose
☐ 2nd influenza dose

Notes:

PRE-CLINIC SCREENING – FOR CLINIC USE ONLY

DOSE ELIGIBILITY:
- ☐ VFC MEDICAID
- ☐ VFC AMERICAN INDIAN/ALASKA NATIVE
- ☐ VFC UNINSURED (NO INSURANCE)
- ☐ STATE UNDERINSURED
- ☐ STATE INSURED

STUDENT NAME

FIN Number

Date of Birth / /