Our Schools are going to
"Teach Flu a Lesson"

For the health of all of our students, faculty, and your family, we encourage you to obtain a flu vaccination for your child with their local healthcare provider or pediatrician.

Healthy Schools LLC. is a Florida based Vaccine for Children Provider that, along with Pasco County Public Schools & The Florida Department of Health in Pasco County, will be offering the **pain-free FluMist® Quadrivalent** vaccine for our students with no deductibles or out of pocket expenses. Medicaid, Florida Kidcare, Aetna, BCBS and other private insurance companies will be billed. Students with no insurance will be provided their flu vaccine at no cost, while supplies last. If you prefer an Inactivated Influenza Vaccine (shot) please contact 1-800-566-0596, and Inactivated Influenza Vaccine forms and Vaccine Information Statements will be sent to you for completion. ALL Inactivated Influenza Vaccine consent forms must be received 5 days prior to the clinic start date.

The "Teach Flu A Lesson" Clinic is **voluntary**. If you wish to participate in this convenient clinic to help keep your child and our schools healthy, you must complete both sides of this form in full. Please use black or blue ink.

Student Information

First name	Middle initial	Last name

Student Date of Birth *(mm/dd/yy)*	Gender	Name of School	Homeroom Teacher	Grade
☐☐ / ☐☐ / ☐☐	☐ Male ☐ Female			

Student Race			
	☐ White	☐ American Indian	☐ Asian
	☐ Black or African American	☐ Hispanic/Latino	☐ Other ____________

Authorizing Parent or Guardian Information

First name	Last name	Relationship
Address	City	Zip

Cell or Emergency Contact Number	Email	Child's Primary Physician

Required Insurance Information

Cardholder Name	Cardholder Birth Date *(mm/dd/yy)*	Contract or Member ID (Include Prefix example PPA, IBU,etc)
	☐☐ / ☐☐ / ☐☐	

Provider:	Medicaid:
☐ Aetna ☐ TRICARE ☐ BCBS ☐ FL Kid Care ☐ Other ____________ Please include the health insurance company name.	☐ Amerigroup ☐ Sunshine ☐ Prestige ☐ Staywell ☐ Uninsured

www.HealthySchoolsllc.com

Please complete the medical information on the reverse side. Vaccinations cannot be given without parent's or guardian's signature.

NEED HELP WITH YOUR APPLICATION?
Visit HealthySchoolsllc.com or call us at 1-800-566-0596.

Healthy Schools

Vaccination & Health Related Questions

1.	Is this child under 9 years of age? (if no, please skip question 2)	Y	N
2.	Has this child received a total of at least 2 doses of flu vaccine since 2009?	Y	N
3.	Does this child have Asthma or reoccurring wheezing?	Y	N
	If yes, has your child used an inhaler and/or suffered wheezing in the past 6 weeks?	Y	N
4.	Has this child ever had a severe or life threatening allergic reaction to the flu vaccine?	Y	N
5.	Does this child have any of the following?	Y	N
	Diabetes or other metabolic disorders	Y	N
	Heart disease or disorders	Y	N
	Kidney disease or disorders	Y	N
	Blood disease or disorders	Y	N
6.	Is this child allergic to vaccine components such as: eggs, gentamicin sulfate, or MSG?	Y	N
7.	Is this child pregnant or nursing?	Y	N
8.	Has this child ever had Guillain-Barre syndrome?	Y	N
9.	Is this child on long term aspirin therapy?	Y	N
10.	Does this child take medications that lower the body's resistance to infection?	Y	N
11.	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? (e.g. an isolation room of a bone marrow transplant unit)	Y	N
12.	Has this child received any other vaccinations in the past 4 weeks? If yes, please list the vaccine name and date of immunization: ____________________	Y	N

Authorization for the Administration of the Influenza Vaccine for:

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____
Student's Name

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 have read the information about the vaccine and special precautions on the Vaccine Information Sheet. 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 had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. 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 Pasco County Public Schools & The Florida Department of Health in Pasco County, Healthy Schools 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 30 days. For the health of all of our students, faculty, and your family, we encourage you to obtain a flu vaccination for your child with their local healthcare provider or pediatrician.

Signature of Parent or Guardian X ______________________ Date *(mm/dd/yy)* __ __ / __ __ / __ __

PLEASE DO NOT WRITE BELOW THIS LINE: ADMINISTRATIVE USE ONLY

Clinic Location: Date:
Vaccine Lot & Expiration Date:
RPH: RN:
VIS CDC LAIV 0.2mL Intranasal

DB:
Filed:
PDF:
Other: