SCHOOL ______________________________

GILA COUNTY DIVISION of HEALTH and EMERGENCY MANAGEMENT

5515 South Apache Ave., Suite 100, Globe, AZ 85501
PHONE: (928) 402-8811 FAX: (928) 425-0794

FLU ADMINISTRATION RECORD AND CONSENT

PLEASE PRINT CLEARLY

Child's **FIRST** Name Middle **LAST** Name ____

Age ________

Child's Date of Birth: Month Day Year ______________________________

Mailing Address ____

☐ Male ☐ Female

Mother's Maiden Name: ________________________________

City: Zip ____

Telephone Number: ________________________________

Please answer the questions below by checking "YES" or "NO" in the box on the left:

YES	NO	
☐	☐	Does your child have an allergy to eggs that causes a dangerous reaction?
☐	☐	Is your child ill and have a fever today?
☐	☐	Has your child had a serious reaction to a previous flu shot?
☐	☐	Has your child had Guillain-Barre Syndrome? (a paralytic illness)

√(check) all that apply:

☐ Uninsured ☐ Native American ☐ AHCCCS* ☐ Have Private Health Insurance*

*Primary Health Plan Name______________________________ Member Name ________________________

MEMBER ID_________________________________ Subscriber's SSN ________________________________

*Secondary Health Plan Name____________________________ Member Name ________________________

MEMBER ID _________________________________Subscriber's SSN ________________________________

ASSIGNMENT OF BENEFITS: I hereby assign to Gila County Health Department any insurance of other third-party benefits available for health care services provided to me. I understand that Gila County Health Department has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Gila County Health Department, I agree to forward the County Health Department all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt.

I Agree to allow the health care provider giving vaccination to release information about all vaccinations given to me, or to the person for whom I am authorized to consent, to the Arizona State Immunization information System (ASIIS), other healthcare providers and the schools in order to avoid receiving unnecessary vaccinations and to provide information in order to receive the vaccination I request.

I have read or have had explained to me the information contained in the Vaccine Information Material (08/15/2019) about the disease and the vaccine. I have the right to ask questions that will be answered to my satisfaction. I understand the benefits and risks of flu shots and authorize the Gila County Office of Health to administer the influenza vaccine to me or the person named below for whom I am authorized to make this request.

Parent/Guardian Signature: ____ Date:________________

Printed Parent/Guardian Signature ______________________________________ Date: _______________

Child's Name________________________________ Date of Birth________________

VFC **INSURANCE / PAID**

INJECTION SITE

LD	RD
LVL	RVL

RN – Screener/Administrators Signature ________________________________ Date: ______________