



Chippewa County Health Department Sault Health Adolescent Care Center

906 632-5690



Providing Flu Shots at School

- Each student must have a flu shot consent form completed with the signature of the parent or guardian. Students are to present the form at the time of the flu shot.
- Include insurance information or \$10.00 (checks payable to Chippewa County Health Department) if no insurance. No student is denied based on inability to pay.
- Please call SHACC with any questions.

VFC Influenza Administration Record

I have read or have had explained to me the information in the attached Vaccine Information Statement. I believe I understand the benefits of the influenza vaccine and ask that the vaccine(s) be given to the person named below for whom I am authorized to make this request. (Date of vaccine information statement 08/06/2021).

First Name _____ M.I. _____ Last Name _____ Sex M F

Birthdate _____ Telephone # _____

Address _____
Street/PO Box Number City State ZIP

Responsible Party: First Name _____ Last Name _____

Address (if different than student) _____
Street/PO Box Number City State ZIP

INSURANCE INFORMATION (check one)

<input type="checkbox"/> Medicaid - ID Number: _____	<input type="checkbox"/> UPHP	<input type="checkbox"/> Straight
<input type="checkbox"/> Self Pay - \$10.00 (student)	<input type="checkbox"/> Uninsured	<input type="checkbox"/> Underinsured
	<input type="checkbox"/> American Indian/Alaska Native	
<input type="checkbox"/> Blue Cross/Blue Shield (attach copy of insurance card) Subscriber: _____	Date of Birth: _____	
<input type="checkbox"/> Other Insurance (attach copy of insurance card) Subscriber: _____	Date of Birth: _____	

CONSENT AND ASSIGNMENT OF BENEFITS AGREEMENT

(Statement to permit payment of benefits to CCHD and allow for administration of vaccine)

I request that CCHD administer the influenza vaccination and I further request that payment of authorized benefits be made to CCHD on my behalf for any services furnished me.

I authorize CCHD to release any medical information needed to determine these benefits for related services.

Signature of parent or guardian or person authorized to make the request.

Date:

*****The questions on page 2 of this form must be completed.*****

Screening Questionnaire for Childhood and Adult Immunizations

The following questions will help determine which vaccines may be given today. If the answer is “yes” to any questions below, it does not necessarily mean the person should not be vaccinated. It just means additional questions may be asked.

Questions to be asked before administering any vaccines:

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the person to be vaccinated have a long-term health problem with heart, lung or kidney disease, asthma, metabolic disease (i.e. diabetes), anemia, or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the person to be vaccinated smoke cigarettes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. In the past 3 months, has the person to be vaccinated taken cortisone, prednisone, other steroids, aspirin or aspirin containing products, anticancer drugs, or had radiation (x-ray) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the person to be vaccinated had a seizure or other nervous system problem.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the person to be vaccinated a healthcare worker.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has the person to be vaccinated received a transfusion of blood or blood products or been given a medicine called immune (gamma) globulin or an antiviral drug in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the person to be vaccinated pregnant or is there a chance of pregnancy during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does the person to be vaccinated travel internationally?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adapted from the Screening Questionnaire for children and teen immunization, screening questionnaire for adult immunization, screening questionnaire for intranasal influenza vaccination, screening questionnaire for injectable influenza vaccination