

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Ron DeSantis
Governor

Dr. Scott A. Rivkees
State Surgeon General

Vision: To be the Healthiest State in the Nation

FY 2019-2020

Dear Parents and Guardians,

Flagler County Health Department, in cooperation with Flagler County Public Schools, is offering your child/children a FREE and EASY opportunity to get the Flu Shot. It is voluntary with parental consent, and will be offered during the school day at all schools.

The State of Florida and its 67 county health departments value the wellness of every child, and want to help them maximize their academic potential by remaining healthy and participating fully in school.

To minimize absences and reduce the transmission of flu, please consider this opportunity to protect your child and family from the flu. Please complete the Consent Form and return it to school **by Monday, October 14th**. All students must have a signed consent form on file and sit willingly for the vaccination (without a parent present) to participate. Please refer to Vaccine Information Statement about FLU SHOT for the most up-to-date information.

Flu Shots will be administered **November 4th- November 18th, 2019** during the school day. Each child who receives a flu shot will also receive written record for parent's files.

We encourage you to take advantage of this SAFE, FREE, and EASY opportunity to protect you child from the Flu. For more information, please contact the Flagler County Health Department at 437-7350, x 7110 or x7069.

Sincerely,

Florida Department of Health-Flagler County

Florida Department of Health

Flagler County Administration
301 Dr Carter Boulevard, P. O. Box 847 • Bunnell, FL 32110
PHONE: 386/437-7350 • FAX 386/437-7353



Accredited Health Department
Public Health Accreditation Board



2019-2020 Seasonal Flu Shot Vaccine Consent Form

QUESTIONS: CIRCLE YES OR NO FOR EACH QUESTION

1. Is your child 4 years or older? YES NO
 2. Do any of the following apply to your child? YES NO

- Allergy to chicken eggs or egg products
- Life threatening reaction(s) to flu vaccine in the past
- Allergy to latex
- Has had Guillain-Barre syndrome(very rare)

(If you answer YES, your child cannot receive a Flu Vaccine at school, please contact your child's doctor)

3. Do any of the below apply to your child? YES NO
- Has long-term health problems with weakened immune system, heart disease, lung disease(e.g. cystic fibrosis), liver disease, kidney disease, or metabolic disorders(e.g. diabetes) or blood disorders(e.g. sickle disease or thalassemia)

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL FLORIDA DEPARTMENT OF HEALTH-FLAGLER COUNTY AT (386)437-7350 EXT 7069

Child's Last Name	Child's First Name	Date of Birth	RACE	SEX
Address	City	State	Zip	Phone / Contact #
Name of School	Homeroom Teacher/Grade			

If possible, attach a copy of your CHILD's Insurance Card front and back.

CHILD's Insurance Company Name _____ Medicaid ID or # _____
 CHILD's Insurance CLAIMS Address (located on your insurance card): _____
 CHILD's Insurance Company Phone Number: _____
 CHILD's Insurance Group #: _____ CHILD's Insurance Member ID Number: _____

PARENTS / GUARDIANS:

I, _____ have the following relationship with the person named above, and have the legal authority (Print name of consenting adult) pursuant to s.743.0645, F.S., to consent to this vaccine administration.

- ____ Father ____ Stepfather ____ Grandfather ____ Adult Brother ____ Adult Uncle ____ Court Order
 ____ Mother ____ Stepmother ____ Grandmother ____ Adult Sister ____ Adult Aunt ____ Legal Guardian

I have received and read the CDC Vaccine Information Statement for the Inactivated Influenza Vaccine 08/15/2019 and I understand the benefits and risks. By signing this consent, I am authorizing the FDOH-Flagler County Staff to administer the Inactivate Influenza Vaccine to the person designated on this form in my absence. I also understand that by my signature below I acknowledge receipt of the notice of privacy rights, and if applicable, I assign the benefits for services to FDOH-Flagler County and authorize FDOH-Flagler County to submit a claim to my insurance company for payment on my behalf. If my insurance denies the claim, I understand I will not be responsible for payment of this service.

Printed Name of consenting adult: _____ Signature of consenting adult: _____ Date: _____

This form is DUE BACK BY October 14th, 2019 FORM REVIEW (INITIALS) / DATE: _____

AREA FOR OFFICIAL USE ONLY FOR ADMINISTRATION

Manufacturer: _____ Lot # _____ Exp. Date: _____

Route: _____ IM Site: _____ RD LD

Administered by(initials): _____ Title _____ Date: _____