MIDFIELD CITY SCHOOLS

A tradition of Excellence & Pathway to Success

Shun Williams
Superintendent

May 1, 2019

Dear Parent(s) or Guardian:

Midfield City Schools will be partnering with **Health Heroes** to provide required and recommended immunizations free to ALL students in the district. This will allow all of our students to be able to update on all required immunizations at the school site needed for school enrollment. This free Immunization Clinic will be held on May 10, 2019, at each school.

The vaccines that will be offered are: (Check ALL that apply)

____ Tdap- Tetanus, diphtheria, pertussis: Ages 11-12 (also 10 years old and entering 6th grade)

____ HPV- Human Papillomavirus: Ages 11-12 with a second dose after 6 months

____ MCV- Meningococcal ACWY: Ages 11-12 with a booster dose recommended at age 16

____ MCVB – Meningococcal B: Ages 16-18 with a second dose after 30 days

_____ _____

Parent Signature Date

If your child meets the age requirement and you want your child to participate, **please complete and return the attached forms** with the desired vaccines checked only. Your signature is required for permission.

If you **DO NOT** wish for your child to be vaccinated during the school clinic, please discard this form and make an appointment with your child's healthcare provider, local health department or pharmacy for these **required** shots.

Pamela P. R.N.

Pam Phillips, MCS Lead Nurse

Dr. Janet M. Jenkins

Dr. Janet M. Jenkins
Midfield City School Coordinator

HEALTH HERO
You Keep Them Smart
We Keep Them Healthy

2019 Flu Vaccine Consent Form

School Name:

PLEASE COMPLETE ALL OF THE INFORMATION BELOW - **Please print using ink** (Incomplete forms will not be accepted)

FIRST NAME of Student:	**LAST NAME of Student:**
Gender: Male Female **Birthdate: (mo,day,yr)**	**Age** **Homeroom Teacher / Grade**
Address	**Home Phone # ( ) -** **Cell Phone # ( ) -**
City **Zip Code** **State**	**Student Race:** (Circle one) African American / Black White Alaskan/ Native American Asian Hispanic Non-Hispanic Hawaiian / Pacific Islander Other :
Email address:	

The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential.

Please fill out the following questions pertaining to your child's Health Insurance:

Medicaid ☐ **My child does NOT have health insurance** ☐	**Insurance Company:**
Policy Holder's First Name:	**Policy Holder's Last Name:**
Member ID:	**Policy Holder's Date of Birth: (mo,day,yr)**

CHECK YES OR NO FOR **EACH** QUESTION

YES	NO	
☐	☐	1. Has your child ever had a life threatening reaction(s) to the flu vaccine in the past?
☐	☐	2. Has your child ever had Guillain-Barre' syndrome?
☐	☐	3. Does your child have an allergy to eggs?
☐	☐	4. Does your child have a blood disorder such as hemophilia?
☐	☐	5. Will this be the first time your child has ever received a flu vaccination?

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL US AT 334-738-4840 TO SPEAK TO A REPRESENTATIVE.

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 at 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 person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine's success. I hereby release the school system, HNH Immunizations, Inc. & subsidiaries, affiliated schools of nursing, their directors and 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 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. Clinic dates can be obtained from the school. I understand that the health related information on this form will be used for insurance billing purposes and your privacy will be protected.

Printed Name of Parent/Guardian _____ Signature of Parent/Guardian _____ Date _____

VIS CDC IIV 08/07/2015 FLUCELVAX
LOT Number: **EXP Date:**
RN #_____ Date:_____
AREA FOR OFFICIAL ADMINSTRATION USE ONLY

HNH Immunizations Inc.
326 Prairie St. North
Union Springs, AL 36089
AL@healthherousa.com
334-738-4840

IMMUNIZATIONS HNH INCORPORATED