SEASONAL FLU VACCINE

This form is to be completed by the parent or legal guardian of the child named below.

STUDENT INFORMATION

Last Name:	First Name:	Grade:
Date of Birth: ❑ Male ❑ Female	School:	
Home Address:		ZIP Code:
City of Residence:	Parent/legal guardian full name:	
Daytime Phone:	Mobile:	I am the student's: ❑ Parent ❑ Legal guardian
Email address (If available):		

HEALTH SCREENING

Has your child ever had a **severe** reaction to a vaccine? ❑ No ❑ Yes- describe:

Does your child have any **severe** allergies to medications, food, **eggs**, or latex? ❑ No ❑ Yes- describe:

Does your child have a condition that lowers immunity (cancer, leukemia) ❑ No ❑ Yes- describe:

Is your child taking medication that lowers immunity (cortisone, other steroids, radiation)? ❑ No ❑ Yes- describe:

Is your child currently receiving aspirin therapy? ❑ No ❑ Yes- describe:

Has your child been diagnosed with asthma or experienced recurrent wheezing? ❑ No ❑ Yes- describe:

Is your child pregnant or nursing? ❑ No ❑ Yes

Please check with your doctor if you are unsure of medical details. Please let us know about any changes in your child's medical condition on the day of vaccination.

CONSENT FOR VACCINATION

I have read and understand the information provided to me about the vaccinations listed below, including risks and side effects.
I GIVE CONSENT for my child, named at the top of this form, to get vaccinated with the vaccines I have checked below during the 2013-2014 academic year. I further understand the School that my child attends (named above) is not liable for the services or vaccinations administered by Health4Chicago.

YES, I GIVE MY CONSENT for my child to receive influenza (Flu) vaccine ❑ Flu Shot: Injection ❑ Flu Mist: Nasal

❑ **NO, I DO NOT** GIVE MY CONSENT for my child to receive the seasonal influenza (Flu) vaccine. REASON:

HEALTH INSURANCE

❑ MY CHILD DOES NOT HAVE INSURANCE

Name of Insured:	Insured's Date of Birth:
Medicaid #:	
Insurance Type (non-Medicaid):	❑ PPO ❑ HMO
Insurance ID #:	Group #:
Employer Name:	

INTERNAL USE ONLY

Vaccine	Date Administered	Site/ Route (Circle One)	Lot Number (Place Sticker)	Immunizer
		RA IM LA IM IN		

I opt out of my child's information being entered in to the Illinois Comprehensive Automated Immunization Registry Exchange, which allows Illinois providers access to my child's immunization records. ❑

I agree to assign insurance benefits to the treating physician. Medical information may be released to my insurance company for the purposes of securing payment for services received. I understand it is my responsibility to understand my benefits and insurance coverage and I will be held responsible for any fees owed for services. **Children uninsured or covered by Medicaid will be given vaccines FREE of charge to parents.**

Parent/Guardian Signature **Date**

HEALTH 4 CHICAGO
UNIVERSITY OF CHICAGO • UNIVERSITY OF ILLINOIS

CONSENT AND RELEASE OF LIABILITY
FOR MEDICAL-RELATED SERVICES PROVIDED BY
[Health4Chicago]

Name of Student _____ Student ID# __ __ __ __ __ __ __ __ __

Student's Date of Birth _____ School Name _____

1. The undersigned, as the parent or legal guardian of the child named above**,** understands that [Health4Chicago], through its network of qualified medical providers ("[Health4Chicago] **Providers**"), offers medical-related services ("**Services**") to City of Chicago residents including Chicago Public Schools ("**CPS**") students and that my child may be eligible to receive these Services.

2. Because different types of Services are offered by [Health4Chicago] Providers, I hereby consent to having my child receive the following types of Services if they become available, without requiring anyone to obtain my additional written consent before my child receives each Service.

Parent/Guardian should check <u>all Services</u> for which this consent is granted:

☐ **Physical Examinations (including blood and urine testing, as appropriate)**

☑ **Immunizations**

☑ **Health Education/Promotion**

☐ **Dental Screening, Examination and Treatment**

☐ **Vision Screening, Examination and Treatment**

This consent does not authorize any Services beyond those listed above. I understand that I will receive prior notice via telephone or in writing of any Services to be provided and that I will have an opportunity to withhold my consent for physical examinations and immunizations on a case-by-case basis. I further understand that I have the right to accompany my child for these visits.

3. I understand that as a substitute caregiver to a Chicago Public School student under the legal guardianship of the Illinois Department of Children and Family Services (DCFS) I am not authorized to provide written Consent for Ordinary and Routine Medical and Dental Care. I further understand that I must request consent from the DCFS Guardianship Administrator, or Authorized Agent, and provide a copy of the DCFS Consent for Ordinary and Routine Medical and Dental Care if consent is granted before any of the above services may be provided.

4. I further grant my consent for the Board of Education of the City of Chicago ("the Board") to release and furnish information regarding past physical exams, immunizations, and vision screening data in my child's health record to Providers to ensure that the Providers can effectively provide services. I also grant my consent for the Providers to release and furnish reports to my child's school for inclusion in my child's health record, and written and verbal reports concerning the results of any screenings and examinations. I understand that such records still will be subject to the privacy rights afforded by state and federal law.

5. **I understand that the Board has no control over Services provided by a [Health4Chicago] Provider. Therefore, if a [Health4Chicago] Provider furnishes the Services, I agree to release and hold harmless the Board, its members, agents, officers, contractors, volunteers and employees from and against any and all claims, demands, actions, complaints, suits or other forms of liability that shall arise out of or by reason of, or be caused by the provision of Services and the treatment received.**

6. I understand that the Provider may bill the Illinois Department of Public Aid's Medicaid/AllKids program or any other currently applicable insurance program for any reimbursable Services it provides and that I may be personally responsible for any co-pay imposed by Medicaid/KidCare or my insurance company. If you have any questions or need more information, call the DHS Helpline at 1-800-843-6154, Monday through Friday (except state holidays), between 8:30 a.m. and 5:00 p.m. Persons using a teletypewriter (TTY) can call 1-800-447-6404. The call is free.

I understand that I may revoke this Consent in whole or in part at any time by sending the Board **and** your child's school <u>prior</u> <u>written</u> <u>notice</u> by fax or mail as follows:

The Board of Education of the City of Chicago
Office of Special Education and Support Services
125 S. Clark Street, Suite 800
Chicago, IL 60603
Attn: Physical Health Fax: 773-553-1883

Copy to: Your child's school Attn: Principal

This revocation will not take effect for seven (7) business days after the Board receives my notice.
Unless I revoke my consent as described above, this Consent will take effect as of the date designated below and it will remain in effect until June 30, 2014.

Parent's/Guardian's Signature: _____

Print Name: _____ Date: _____