Dear Parents/Guardians,

Genesis will be offering FREE seasonal flu vaccines at your child's school this fall. The ***Genesis Flu-Free Quad Cities*** program is sponsored by: Genesis Health Services Foundation, Clinton County VNA Foundation, and gifts from private individuals and corporate donors in our communities. Vaccination is one of the best ways to protect your child against the flu. **Our goal is to keep your children and those they come into contact with, healthy this flu season!**

Vaccines will be administered at your child's school on Oct. 3 (Thursday) in the afternoon

- If you would like your child to receive a free seasonal flu vaccine at school, we need your permission.
- **COMPLETE** the consent form. It is important that you answer **ALL** of the questions and **SIGN** and **DATE** the form. **ONLY** legal guardians and parents should sign.
- Return the completed consent form to the school by Sept. 30th.
- **If you do not wish for your child to have the vaccine, DO NOT fill out or return the consent to the school.**

The Vaccine Information Statement (VIS) may be on your school district website or you may view the VIS on the following site: www.cdc.gov/vaccines/ or www.immunize.org. Please take time to read this information. It should answer any questions you may have about the flu vaccine.

This program does **not** include a second clinic at your child's school for those children that may require a second vaccine. The information sheet that your child will bring home after their vaccine will help you determine whether your child will need a second dose of flu vaccine. Your local health department or primary care physician will be able to assist you as well.

If you have any questions regarding ***Genesis Flu-Free Quad Cities*** program, please contact Cheryl Thorsen (563) 244-4944,or Michele Cullen (563) 244-4923 or (563) 242-7165. Thank you for helping to make your child's school and community a healthier place.

Student Flu Vaccine Consent & Release Form

PLEASE PRINT **COMPLETE FORM FOR EACH CHILD**

STUDENT'S NAME (Last)	(First)	(M.I.)	**STUDENT'S DATE OF BIRTH** / /	
PARENT/GUARDIAN'S NAME (Last)	(First)	(M.I.)	**Circle Gender** M F	**Student's Age**
ADDRESS			**PHONE:** **Daytime:** **Home:** **Cell:**	
CITY and STATE	**ZIP**			
SCHOOL NAME	**SCHOOL TOWN**		**GRADE**	
HOMEROOM TEACHER'S NAME (Last, First) and **HOMEROOM NUMBER**			**PHYSICIAN'S NAME:**	

This vaccination program is free to all elementary students; however, for program purposes we need the following information.
Please check the section that applies to your child: ( ) Medicaid Enrolled ( ) has no health insurance
( ) American Indian/Alaskan Native ( ) Has health insurance that does NOT pay for influenza vaccines
( ) Has health insurance that DOES pay for influenza vaccines

The following questions will help us to determine if your child can get the influenza vaccine.

Please mark **YES** or **NO** for each question:

	YES	**NO**
1. Does your child have a serious allergy to eggs?	☐	☐
2. Does your child have any other serious allergies? Please list:	☐	☐
3. Has your child ever had a serious reaction to flu (influenza) vaccine in the past?	☐	☐
4. Has your child ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness)?	☐	☐

Consent for Child's Vaccination

I have read the Vaccine Information Statement for the ***Inactivated Influenza Vaccine for the 2019-2020 season*** or have had the information explained to me. I have had a chance to ask questions, which were answered to my satisfaction. I understand and acknowledge the benefits and risks of influenza vaccine and request that the vaccine be given to my child at school. I accept responsibility for seeking medical attention for any problems with this vaccination. I understand that if my child requires two doses of flu vaccine, it is my responsibility to get this second dose for my child. I acknowledge that I have read a Genesis Health System Notice of Privacy Practices. **I give consent for my child, for whom I am authorized to make this request, to Genesis and its' staff for my child to be vaccinated at school.**

Signature of Parent/Guardian ______________________ Date: ______/_____/_____

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Site	Route	Vaccine Manufacturer	Lot Number	Expiration Date
2019-2020 Inactivated Influenza	/ /	RD LD	IM 0.5 ml			
Name & Title of Vaccine Administrator:						