BALTIMORE CITY
PUBLIC SCHOOLS

Maryland Partnership for Prevention

Dear Parent/Guardian,

Flu vaccinations are coming to your child's school. They will be given at no cost to you. If you have insurance, your insurance company will be billed. **You will NOT be charged a copay or deductible.**

If you would like your child to be vaccinated, by **October 15**:

FILL OUT A CONSENT FORM ONLINE AT:

www.vaccineconsent.com

OR

FILL OUT A PAPER CONSENT FORM

1. Read the Vaccine Information Statement, which can be found at https://tinyurl.com/HoCoFluVis or in your school nurse's office.

2. Fill out and return the form that is on the back of this letter. Be sure to:
   - Fill out every section and write neatly in ink.
   - Use your insurance card to fill out your insurance information. Your child will still be vaccinated if they do not have insurance.
   - Return the consent form **no later than October 15**.

Every year, millions of people get sick and many die from the flu. Vaccinations are one of the best ways to help keep your family healthy and in school and at work.

Once again, we will work with the health department and the Maryland Partnership for Prevention (MPP) to offer flu vaccinations. The clinic at your child's school will be held in October or November. We will send a notice home the day he/she has been vaccinated.

We hope you will join our fight against the flu. We look forward to preventing the flu with you!

Sincerely,
Maryland Partnership for Prevention & Baltimore City Public School System

Turn over for consent form

School Nurse

BALTIMORE CITY County Public Schools Consent Form for
SY 2019-20 INJECTABLE Flu Clinic

Please Print Clearly in Ink

Fill out this section

Student's LAST Name	Student's FIRST Name	M.I.	Student's Birthdate / /	Age	Gender F M Other	Grade
Parent/Guardian LAST Name	Parent/Guardian FIRST Name	M.I.	Cell/Daytime Phone			
Address			Email Address			
City	ZIP Code		School Name		Teacher/Homeroom	

Fill out this section

HEALTH INSURANCE INFORMATION – PLEASE FILL OUT COMPLETELY AND ACCURATELY

Please copy this information from YOUR INSURANCE CARD. We will bill your insurance. You will NOT be charged a co-pay or a deductible.

Type of Insurance: ☐ Medical Assistance ☐ Private Insurance ☐ My child does not have health insurance (Your child will not be turned away because of no insurance)

Name of Insurance Company	Member ID Number (write in boxes below)
	Group Number

FOR **PRIVATE INSURANCE** ONLY

Policy Holder's/Insured Adult's Name	Relationship to Student	Insured Adult's Birthdate / /	Any Other # from Insurance Card

Answer these

1. Do any of the following apply to your child? ***(If you answer YES to any question, your child might not be vaccinated.)***

Yes	No		Yes	No	
☐	☐	Has had a serious reaction to a flu vaccine in the past?	☐	☐	Has had Guillain-Barre syndrome?
☐	☐	Has an allergy to a component of the vaccine?	☐	☐	Has serious allergies to a medication, food, or latex? If "yes", explain:_____

If your child is under 9 years old and has not had a flu vaccination before, she/he may need a second flu vaccination this year. Please check with your health care provider to see if your child needs a second "dose" of the vaccine.

If you have any questions about flu vaccine, please contact your child's doctor or the health department or go to www.flu.gov.

CONSENT FOR VACCINATION(S) – YOU MUST SIGN HERE FOR YOUR CHILD TO BE VACCINATED

By signing this form, I give permission for my child to be vaccinated, my insurance company to be billed for the service, the vaccinaction to be entered into ImmuNet, and Maryland's immunization registry. Further, I agree that:

(1) The information above is correct; (2) I have read the Vaccine Information Statement dated 8/7/15 or someone has read it to me;
(3) I understand the risks and benefits of getting the vaccine I have consented for my child to receive; and
(4) Any questions I had about the vaccine(s) have been answered;

Signature of Parent/Legal Guardian_____ **Date:** ____/____/____

FOR OFFICE USE ONLY

Date of Administration / VIS Given	Vaccine	Vaccine Manufacturer	Lot Number	PRINT Name of Vaccine Administrator