

## 2023-2024 Seasonal Flu Mist Vaccine Consent Form THIS FORM MUST BE RETURNED

PLEASE COMPLETE THE INFORMATION BELOW (Unreadable and incomplete forms may not be accepted.)

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Full, Legal Name of Student (First Name Middle Initial. Last Name) PLEASE PRINT		Name of School	
Parent/Guardian Name (First Name Middle Initial. Last Name)	Relationship to Student	Homeroom Teacher	Grade
Street Address	Email Address	Birth Date (month/date/year)	Age Sex
City:	Zip Code	Home Phone #	Cell Phone #
Demographic Information: (Circle one) White American Indian/Native Alaskan Black Asian Hispanic Other			
INSURANCE MEDICAID (Prestige, UHC Community, StayWell/WellCare, & Sunshine) MY CHILD DOES NOT HAVE HEALTH INSURANCE			
The current health care laws require us to bill your insurance company for the vaccine. You will not be billed, and there will be no co-pay or deductible due. The service is offered at no cost to you! As always, answers are confidential. Please fill out the following questions regarding your child's health insurance plan:  Insurance Company/Medicaid Plan  Member ID:			
Policy Holder's Name:	Policy Holder's Date	of Birth:	
HEALTH QUESTIONS: CHECK YES OR NO FOR EACH QUESTION			
1. Do any of the following apply to your child?			
Printed Name of Parent/Guardian	Signature of Parent/Guar FICIAL USE ONLY FOR ADMINISTI		Date
MedImmune (MED) FluMist, Intranasal (NAS), 0.2ml VIS: 08/6/2021  Date Given: Signature/Title	Nurse/clinic notes;	KATION	
Notes:			

Please return to the school, FAX to (352) 334-7947, or EMAIL to; SLIV@flhealth.gov (Please note that e-mailing may not be a secure method of communication)