

IMMUNIZATION PERMISSION FORM

School Site Flu Immunization Initiative

Please complete both sides of this form and return to your child's school no later than September 29, 2025.

INFORMATION ABOUT YOUR CHILD

Child's Legal Name:			Date of Birth:		
Age:	Sex:	Race:		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
School:		Grade:	Teacher:		
Home Address:					
City:			State:	ZIP:	
Phone Number:					
Parent/Guardian Name:			Relationship to child:		
Emergency Contact Name:			Emergency Contact Phone:		
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (please specify):					

Has this child ever had a serious allergic reaction to influenza vaccine? Yes No

Has this child ever had Guillain-Barré syndrome? Yes No

CHECK ALL THAT ARE TRUE AND SIGN BELOW

VACCINATION AUTHORIZATION & ACKNOWLEDGEMENT OF VIS

- Yes, I give permission for my child to receive **flu vaccine** as indicated at school.
- I have received and reviewed the *Vaccine Information Sheet (VIS)* for flu vaccine.

ACKNOWLEDGEMENT OF PRIVACY NOTICE

Transylvania Public Health's privacy notice is available at transylvaniahealth.org/SchoolFlu. Your signature below acknowledges that we have given you a copy of our Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us.

- I have received the Transylvania County's Privacy Notice.
- I have been given a chance to discuss my concerns and questions about the privacy of my health information.

Patient Signature (Parent/Guardian Signature if patient under 18)

Date

HEALTH INFORMATION EXCHANGE NOTIFICATION

Transylvania Public Health participates in the NC HealthConnex health information exchange. Your information will be automatically included in this secure system after each visit. If you prefer not to participate, you can complete the Patient Opt-Out form and send it to the NC HIEA business office. Forms are available on the NC HIEA website (nchealthconnex.gov) and in our lobby.

(COMPLETE OTHER SIDE)

VACCINE COST AND BILLING INFORMATION

The flu vaccine costs \$41. Children who have no insurance or Medicaid receive these vaccines at no cost. Many private insurance carriers cover vaccines at 100%.

Many private insurance carriers cover vaccines at 100%. If your child has insurance coverage through Aetna, Blue Cross Blue Shield, or Cigna, we can file a claim on your behalf for your child’s vaccinations. (For employees of HCA who are covered by their Aetna plan, please note that we are unable to process this insurance due to their plan restrictions, and the cost will not be reimbursed by this plan.) Your signature on the reverse side of this form authorizes Transylvania Public Health to release information necessary for the processing of any claim for payment. You will receive an invoice for the amount not covered by insurance.

If you have a different private insurance carrier, we will accept payment via check made payable to Transylvania Public Health or by contacting us at 828-884-3135 and asking to arrange for pre-payment of the school flu vaccine. We will provide a receipt for you to claim reimbursement from your insurance carrier.

Please note other insurance carriers consider Transylvania Public Health to be an out-of-network provider. Payment must be received before the flu vaccine can be given to your child.

FEDERAL FUNDING/INSURANCE INFORMATION

This child is American Indian or Alaskan Native *(This information is required for insurance billing and federal funding purposes. It will not prevent your child from receiving vaccines through this program and will not be shared with anyone.)*

This child has the following insurance coverage: *(This information is very important for billing purposes.)*

Not insured / no medical coverage

Medicaid Recipient I.D. _____

Aetna (not HCA) Subscriber Name _____ Subscriber DOB _____
Subscriber ID _____

Blue Cross Blue Shield Subscriber Name _____ Subscriber DOB _____
Subscriber ID _____ Member # ____ (01, 02, etc.)

Cigna Subscriber Name _____ Subscriber DOB _____
Subscriber ID _____

Other insurance Please pay \$41 via check or call 828-884-3135 to arrange for payment.

For office use only:

Transylvania County staff should complete if ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE is not signed:

Does patient have a copy of the Privacy Notice? Yes No

Please explain why the patient was unable to sign the form and Transylvania County’s efforts in trying to obtain the signature:

Consent form should be present with the child at the time of vaccination for verification of parental consent and accurate documentation.

Does this child currently have a fever with a temperature above 100 F? Yes No

Date Given	Type	Site/Route	Mfr./ Lot #		Date VIS Printed	Date VIS Given	Nurse Signature
			private	state supply			
	Flu	<input type="checkbox"/> L <input type="checkbox"/> R Deltoid/IM	<input type="checkbox"/> U8863DA <input type="checkbox"/> UT8770JA	<input type="checkbox"/> UT8792MA <input type="checkbox"/> UT8802MA	1/31/25	9/17/25	

Checked NCIR: Yes No