Influenza Registration and Medical Release

Client Name _____ **Date of Birth** _____

Address _____ **Apt No.** _____

City _____ **ZIP**_____ **Phone** _____

Social Security Number _____ **Race** _____ **Sex** _____
OPTIONAL

Services Requested

I request the following vaccination from the Florida Department of Health School-Based Clinic:

☐ Influenza (flu shot)

Agreement for Student Services

Please read carefully and sign:

I do hereby give my consent for the above-named student to receive the flu shot at the Florida Department of Health School-Based Clinic. I further understand that all services authorized by myself will be available at no cost.

Please check one: ☐ **Parent** ☐ **Legal Guardian** ☐ **Student (if 18 or older)**

Print Name: _____ Signature: _____ Date: _____

Medicaid Coverage Consent

Is your child covered by Medicaid? ☐ Yes ☐ No (If Yes, please continue. If No, please stop here.)

State of Florida Consent for Billing Medicaid

Although all school-based clinic services are available at no cost to you, the Florida Department of Health does receive partial financial assistance by billing Medicaid for students with Medicaid coverage. If your child is indeed covered by Medicaid, please sign the following consent.

I hereby assign the Florida Department of Health all benefits provided under the Medicaid health care plan. The amount of such benefits shall not exceed the medical charges set forth by the Pinellas County Board of Commissioners. All payments under this paragraph are to be made to the Florida Department of Health. I further authorize the Florida Department of Health at 205 Dr. M. L. King Jr. Street North, St. Petersburg, FL 33701 and any physician or healthcare provider examining or treating my child to release to any third party for any medical, psychiatric/psychological, alcohol/drug abuse, sexually transmitted disease, tuberculosis, AIDS, HIV, abuse or case management information including information received from other health care providers, concerning diagnosis and treatment for its use in determining a claim for such diagnosis or treatment. This may include any and all information pertaining to payment.

Please check one: ☐ **Parent** ☐ **Legal Guardian** ☐ **Student (if 18 or older)**

Print Name: Signature: Date:

-- OFFICE USE ONLY--

Lot # _____	**Route_____Site _____**
School-Based Health Clinic: GHS: ___ PPHS: ___ LHS: ___ NEHS: ___ BCHS: ___	
☐ **Egg-free Influenza (FLUBLOK) 90630**	**Nurse Signature _____**