2024-2025 School Year Flu Clinic

McFarland Clinic, in partnership with your school, will be providing a school based flu vaccine clinic for staff during school hours. McFarland Clinic will be able to bill insurance companies for your flu vaccine.

If you would like to receive a flu vaccine at school, please fill out the consent form and return it to the school with insurance information or a copy of your insurance card by **October 1st**. We will be unable to vaccinate anyone without completed paperwork. If you chose not to bill insurance, the cash price for the flu vaccine will be $72.

The school based flu clinics for staff and students at Glidden-Ralston Community Schools are scheduled for **October 17th.**

Please contact McFarland Clinic if you have any questions at 712-792-1500.

Thank you!

Consent for Flu Shot-Adult

I have read the statement about the flu vaccine and the special precautions. I understand the benefits and risks.

Do you have an allergy to eggs, thimerosal or products containing mercury?	Yes ______	No ______
Do you currently have an illness with fever?	Yes ______	No ______
Have you received another vaccine within the last 14 days?	Yes ______	No ______
Have you been diagnosed with Guillain Barre Syndrome?	Yes ______	No ______

Please bring a front/back copy of your insurance card

Full Name_____________________________________ M___F___DOB_______Age_______
Address____
City, State____Zip Code_________________
Phone Number_______________________________________
Family Doctor________________________________Clinic/City________________________

Date VIS reviewed_________________________

Signature____Date_________________

FOR OFFICE USE ONLY	Name of Vaccine: Fluzone 0.5 mL
Manufacturer: Sanofi Pasteur	Route of Administration: IM
Lot:	Exp:
V_____________ P_____________	
Site:	Administered by:

Consent for Flu Shot-Student

I have read the statement about the flu vaccine and the special precautions. I understand the benefits and risks. I request that the vaccine be given to me or to the person named below of which I am the parent or guardian.

Has your child had a serious reaction to eggs, thimerosal or products containing mercury?	Yes ______	No ______
Does your child currently have an illness with fever?	Yes ______	No ______
Has your child received another vaccine within the last 14 days?	Yes ______	No ______
Has your child ever had Guillain-Barre Syndrome?	Yes ______	No ______

Please send a front/back copy of your insurance card

Full Name of Child________________________________ M___F___DOB_______Age_______
Address____
City, State____Zip Code_________________
Phone Number____
Family Doctor___________________________________Clinic/City________________________
If billing address is different please provide below:

Date VIS reviewed__________________________
Signature____Date__________________

FOR OFFICE USE ONLY	Name of Vaccine: Fluzone 0.5 mL
Manufacturer: Sanofi Pasteur	Route of Administration: IM
Lot:	Exp:
V___________ P___________	
Site:	Administered by: