



2010-2011 SEASONAL INFLUENZA SCHOOL VACCINATION CONSENT FORM

SCHOOL NAME	GRADE
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SECTION 1: INFORMATION ABOUT STUDENT (PLEASE PRINT)

Student's Name (Last)	(First)	(M.I.)	Student's Date of Birth Month _____ Day _____ Year _____	
Parent/Legal Guardian's Name (Last)	(First)	(M.I.)	Student's Age	Student's Gender Male <input type="checkbox"/> Female <input type="checkbox"/>
Address			Parent/Guardian Daytime Phone Number:	
City	State	Zip	Name of Child's Primary Health Care Provider	

SECTION 2: HEALTH INSURANCE INFORMATION

Indicate your child's health insurance provider (or indicate if your child is uninsured). <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Neighborhood Health Plan <input type="checkbox"/> Federal Blue Cross/Blue Shield <input type="checkbox"/> Tufts <input type="checkbox"/> United Healthcare <input type="checkbox"/> No insurance <input type="checkbox"/> Rite Care <input type="checkbox"/> Other (please specify below):	If your child has health insurance, please provide his or her subscriber identification number:
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SECTION 3: SCREENING FOR VACCINE ELIGIBILITY

A. If you answer "YES" to any of the questions in Section 3A (1-4) your child <u>cannot</u> get vaccinated at school. Contact your child's doctor to discuss other options.	YES	NO
1. Does your child have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your child ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) after receiving flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is your child pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
B. Please answer the following additional questions about your child's medical history.	YES	NO
5. Does your child have any other serious allergies? Please list:	<input type="checkbox"/>	<input type="checkbox"/>
6. Has your child received any vaccines (not just flu) within the past 30 days?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child have asthma, diabetes, or disease of the lungs, heart, kidneys, liver, nerves, or blood?	<input type="checkbox"/>	<input type="checkbox"/>
8. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your child have a weak immune system from HIV, cancer, or medications such as steroids or those used to treat cancer?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 4: CONSENT FOR CHILD'S VACCINATION IN SCHOOL

I have answered **NO** to the questions in Section 3A (1-4). I have read, or have had explained to me, the 2010 Injectable Influenza Vaccine Information Statement and the 2010 Intranasal Influenza Vaccine Information Statement. I understand the benefits and risks of the vaccine and ask that the influenza vaccine be given to the student named above for whom I am authorized to make this request.

I understand that I can review a Notice of Privacy Practice at the time of vaccination.

Signature of Parent/Legal Guardian _____ Date: _____

SECTION 5: FOR ADMINISTRATIVE USE ONLY VIS Date: 8/10/2010

Vaccine	Date Dose Given	Route	Manufacturer	Lot Number	Name and Title of Vaccine Administrator
Influenza		<input type="checkbox"/> IM <input type="checkbox"/> Intranasal			