



2011-2012 SEASONAL INFLUENZA SCHOOL LOCATED VACCINATION CONSENT FORM

Last Name <i>(Please print)</i>	First Name	MI	Date of Birth Month ___ Day ___ Year ___	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address		City	State	Zip
Parent/Guardian/Patient Daytime Phone Number		Parent's Email		Name of Primary Healthcare Provider
If student, print name of school he/she attends:			Grade	Age

HEALTH INSURANCE INFORMATION

Indicate insurance provider and subscriber number ~ please include all letters/numbers.

	Please check if Primary Ins
<input type="checkbox"/> Blue Cross/Blue Shield _____	<input type="checkbox"/>
<input type="checkbox"/> Neighborhood Health Plan _____	<input type="checkbox"/>
<input type="checkbox"/> UnitedHealthcare Subscriber ID # _____ Group # _____	<input type="checkbox"/>
<input type="checkbox"/> Tufts _____	<input type="checkbox"/>
<input type="checkbox"/> Medicare _____	<input type="checkbox"/>
<input type="checkbox"/> None of the above/No insurance - \$20 (adults) \$0 (students)	
My insurance Provider is _____ Insurance ID # _____	

SCREENING FOR VACCINE ELIGIBILITY

<i>If "YES" to any question 1-4, we cannot vaccinate at school. Please contact your doctor to discuss options.</i>	YES	NO
1. Any serious allergy to eggs?		
2. Ever had a serious reaction to a previous dose of flu vaccine that required medical attention?		
3. Ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) after receiving flu vaccine?		
4. Any allergy to Thimerosal or Latex?		
<i>Answer the following questions ONLY if intranasal vaccine (FluMist) is preferred.</i>	YES	NO
5. Is the person who is to receive the vaccine between 2yrs and 49yrs of age?		
6. Received any vaccines (not just flu) within the past 30 days?		
7. Has asthma, diabetes, or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
8. Is the person on long-term aspirin or aspirin-containing therapy (aspirin every day)?		
9. Has a weak immune system from HIV, cancer, or medications such as steroids or those used to treat cancer?		

CONSENT FOR VACCINATION IN SCHOOL SETTING

I have answered "NO" to questions 1-4. I have read, or have had explained to me, the 2011 Injectable Influenza Vaccine Information Statement and/or the 2011 Intranasal Vaccine Information Statement. I understand the benefits and risks of the vaccine.

Injectable Vaccine **FluMist Vaccine** (intranasal)

The vaccine checked above should be given to the person 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/Guardian/Patient _____ Date _____

Print Last Name _____ Print First Name _____

FOR ADMINISTRATIVE USE ONLY					VIS Date: 2011 Flu Season
Vaccine	Date Given	Route	Manufacturer	Lot No.	Signature of Vaccine Administrator
Influenza		<input type="checkbox"/> IM R L <input type="checkbox"/> Intranasal			