

# 2012-2013 SEASONAL INFLUENZA SCHOOL LOCATED VACCINATION CONSENT FORM



Last Name ( <i>Please print</i> )	First Name	MI	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address		City		State	Zip
Phone Number		Email		Name of Doctor	
If student, print name of school he/she attends:				Grade	
Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Unknown or Other Race					
Ethnicity: <input type="checkbox"/> non Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unknown					

HEALTH INSURANCE INFORMATION	
<i>Indicate insurance provider and subscriber number ~ please include all letters/numbers.</i>	
<input type="checkbox"/> Blue Cross & Blue Shield _____	<input type="checkbox"/> Tufts _____
<input type="checkbox"/> Neighborhood Health Plan _____	<input type="checkbox"/> Cigna _____
<input type="checkbox"/> UnitedHealthcare _____ Group # _____	
<input type="checkbox"/> Medicare _____ <input type="checkbox"/> Other or No Insurance: 19yrs and older - \$20, Students under 19yrs - \$0	

SCREENING FOR FLU VACCINE ELIGIBILITY		
<i>If "YES" to any question 1-4, we cannot vaccinate at school. Please contact your doctor to discuss options.</i>		
1. Any serious allergy to eggs?	Yes	No
2. Has your child ever had a serious reaction to previous dose of flu vaccine that required medical attention?	Yes	No
3. Ever had Guillain-Barre Syndrome (temporary severe muscle weakness) after receiving flu vaccine?	Yes	No
4. Any allergy to Thimerosal or Latex?	Yes	No

Answer the following questions <u>ONLY</u> if intranasal (FluMist) is preferred		
5. Has your child received any vaccines (not just flu) within the past 30 days?	Yes	No
6. Does your child have asthma, diabetes, or disease of the lungs, heart, kidneys, liver, nerves, or blood?	Yes	No
7. Is your child on long-term aspirin or aspirin-containing therapy (aspirin every day)?	Yes	No
8. Does your child have a weak immune system from HIV, cancer, or medications such as steroids or those used to treat cancer?	Yes	No

CONSENT FOR VACCINATION IN SCHOOL SETTING	
<b>Please check one:</b> <input type="checkbox"/> <b>Injectable Vaccine</b> <input type="checkbox"/> <b>FluMist Vaccine (intranasal)</b>	
I have answered "NO" to questions 1-4. I have read, or have had explained to me, the 2012 Injectable Influenza Vaccine Information Statement and/or the 2012 Intranasal Vaccine Information Statement. I understand the benefits and risks of the vaccine.	
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: 07/02/2012
Vaccine <i>Influenza</i>	Date Given	Route <b>IM R L</b> <i>Intranasal</i>	Manufacturer	Lot No.	Signature of Vaccine Administrator