

2010 - 2011 INFLUENZA VACCINE CONSENT AND SCREENING FORM

Injectable (Flu Shot) or Nasal Spray Vaccines

Section 1: Information about the student to receive vaccine (please print):

Name: (Last, First, MI)		Date of birth:		Age	Sex: (Circle)
		Month	Day	Year	Male Female
Street Address:				Student grade:	
City:	State:	Zip:	Phone:		
			()		

Section 2: Consent for Vaccination

CONSENT FOR CHILD'S VACCINATION: I have read or had explained to me the 2010-2011 Vaccine Information Statement for the influenza vaccine and understand the risks and benefits.

I GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine. Children younger than 9 years of age may need 2 doses of vaccine. (If this consent is not signed, dated and returned, my child will not be vaccinated.)

I DO NOT GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine.

Signature of Parent/Legal Guardian

Date

Signature of Parent/Legal Guardian

Date

Section 3: Permission to Share Information:

I, _____, give permission to the individual and/or entity that administered the 2010 - 2011 influenza vaccine to my child _____ to share copies of the 2010 - 2011 flu vaccine consent form and vaccination record with my child's school and health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2010/11 seasonal influenza consent form and vaccination record with each other.

(Print your name)

(Print child's full name)

My child's health care provider:

Name: _____

Address: _____

My child's school:

Name: _____

City or town: _____

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
- This permission expires at the end of the 2010 - 2011 school year.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my child's ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

(School/institution/individuals handling withdrawals must insert name and address)

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.

Signature of Parent or Guardian

Printed name of Parent or Guardian

Address: _____

Date signed: ____/____/____

Screening for Injectable (Flu Shot) or Nasal Spray Vaccines

Answering these questions will help us to know which type of flu vaccine your child should get and whether your child should get 1 or 2 doses of flu vaccine.

Section 1: Information to determine if your child should receive 1 or 2 doses of flu vaccine

Is your child 8 years old or younger? ☐ Yes ☐ No **If no, go to Section 2.**

If your child is 8 years old or younger, please answer the next 2 questions:

Has your child received at least 2 seasonal flu vaccines in his/her life time? ☐ Yes ☐ No

Has your child received at least one dose of H1N1 vaccine since October 2009? ☐ Yes ☐ No

Section 2: Information on flu vaccines already received this flu season

Has your child received flu vaccine this flu season (since August 1, 2010)? ☐ Yes ☐ No **If no, go to Section 3.**

If yes, please tell us the number of doses and dates of vaccination.

o Dose 1 Date received: month ____ day ____ 2010

o Dose 2 Date received: month ____ day ____ 2010

Section 3: Information to determine if your child should receive the 2010-2011 seasonal flu vaccine.

Please check YES or NO for each question.

A. If you answer "YES" to one or more of the 4 questions, your child will not be able to get flu vaccine in school unless there is a note from your child's health care provider saying it is okay for your child to get flu vaccine. If you answer "NO" to all these questions, your child will receive the vaccine. If you are not sure of the answers, check with your child's healthcare provider.

	NO	YES
1. Can your child eat eggs without problems?		
2. Does your child have a serious allergy to gentamicin, neomycin, polymixin or gelatin?		
3. Has your child ever had a serious reaction to a flu vaccine in the past?		
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

B. There are 2 kinds of flu vaccine available. Your answers to the following questions will help us decide if your child is able to receive the nasal spray (live) vaccine. If your child cannot get the nasal spray vaccine, he/she will be given the flu shot.

	NO	YES
1. Has your child received any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: _____ Month Day Year		
2. Does your child have asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
3. If your child is younger than 5 years old, has a healthcare provider told you that your child had wheezing or asthma within the last 12 months?		
4. Does your child take aspirin or aspirin-containing medicine every day?		
5. Does your child have a weak immune system (from HIV, cancer, or medicines such as steroids or those used to treat cancer)?		
6. Is your child pregnant?		
7. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?		

List all serious allergies:
