2013 - 2014 School-located Flu Vaccination Consent Form

Last Name *(Please print)*	First Name	MI	Date of Birth	☐ Male ☐ Female

Address	City	State	Zip

Phone Number	Email	Name of Doctor

If student, print name of school he/she attends:	Grade

Race: ☐White ☐Asian ☐Black or African American ☐American Indian or Alaska Native ☐Native Hawaiian or Other Pacific Islander ☐ Unknown or Other Race

Ethnicity: ☐ non Hispanic or Latino ☐Hispanic or Latino ☐ Unknown

HEALTH INSURANCE INFORMATION

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

☐ Blue Cross & Blue Shield_____ ☐ Tufts_____

☐ Neighborhood Health Plan_____ ☐ Tufts/Carelink_____

☐ UnitedHealthcare_____ Group #_____

☐ Medicare_____ ☐ Other or No Insurance

SCREENING FOR FLU VACCINE ELIGIBILITY

If "YES" to any question 1-4, we cannot vaccinate at school. Please contact your doctor to discuss options.

1.	Any serious allergy to eggs?	Yes	No
2.	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 Thimerosol or Latex?	Yes	No

Answer the following questions <u>ONLY</u> if intranasal (FluMist) is preferred (approved for people 2 – 49 yrs.)

5.	Received any vaccines (not just flu) within the past 30 days?	Yes	No
6.	Have asthma, diabetes, or disease of the lungs, heart, kidneys, liver, nerves, or blood?	Yes	No
7.	On long-term aspirin or aspirin-containing therapy (aspirin every day)?	Yes	No
8.	Have a weak immune system from HIV, cancer, or medications such as steroids or those used to treat cancer, or are in close contact with a person who needs care in a protected environment?	Yes	No

CONSENT FOR VACCINATION IN SCHOOL SETTING

Please check one: ☐ **Injectable Vaccine** ☐ **FluMist Vaccine** (intranasal)

I have answered "NO" to questions 1-4. I have viewed the Vaccine Information Statement(s) at www.immunize.org or viewed a hard copy obtained by calling the Rhode Island Department of Health (401-222-5960). 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: 07/26/2013**

Vaccine	Date Given	Route	Manufacturer	Lot No.	Signature of Vaccine Administrator
Influenza		**IM** *R L* *Intranasal*			