20__ Flu Vaccine Consent Form

Section 1: Information about Child to Receive Vaccine (*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**
ADDRESS			**PARENT/GUARDIAN DAYTIME PHONE NUMBER(S):**	
CITY	**STATE**	**ZIP**		
STUDENT'S HEALTH CARE PROVIDER NAME (Last, First)				
ADDRESS	**CITY**		**STATE**	**ZIP**
SCHOOL NAME	**HOMEROOM TEACHER'S NAME**		**GRADE**	

Section 2: SCREENING for Vaccine Eligibility

Please mark YES or NO for each question.

The following questions will help us to know if your child can get the intranasal influenza vaccine. If you answer "NO" to all of them, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following questions, your child may be able to get the influenza vaccine, but we will contact you to discuss your options.	**YES**	**NO**
1. Does your child have a serious allergy to eggs?	☐	☐
2. Does your child have any other serious allergies? Please list:	☐	☐
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐

Section 3: CONSENT

CONSENT FOR CHILD'S VACCINATION: I have read or had explained to me the 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.)

_____ _____

Signature of Parent/Legal Guardian *Date*

I <u>DO NOT</u> GIVE CONSENT to Natick Public Schools/ Natick Board of Health and its staff for my child named at the top of this form to be vaccinated with this vaccine.

_____ _____

Signature of Parent/Legal Guardian *Date*

Section 4: Insurance Information (ON OTHER SIDE)

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information

PLEASE FILL OUT <u>BOTH</u> SIDES OF THIS FORM and RETURN NO LATER THAN_____(DATE)

20__ Flu Insurance Information Form

Section 4: Insurance Information

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): *REQUIRED FIELDS

Name: (Last, First, MI)*	Date of birth: * _____ _____ _____ Month Day Year	Age*	Gender: *
Street Address:*			
City:*	State: *	Zip:*	Phone:* ( )

Insurance Information: Include the whole member ID number and any letter that are part of that number

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)

*Place Photo Copy of All Insurance Cards Here:

If person getting vaccinated is NOT the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * _____ _____ _____ Month Day Year	Gender:*
Subscriber's Street Address:* (If different from address above) ☐**SAME AS ABOVE**		

City:*	State: *	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other			

I give permission for my child to be vaccinated and for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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Section 5: Vaccination Record: (For Administrative Use Only)

For children 18 years of age and younger:

Is Vaccine for Children (VFC) Program eligible:
- ___ Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
- ___ Does not have health insurance
- ___ Is American Indian (Native American) or Alaska Native

Is not VFC-eligible:
- ___ Has health insurance and is not American Indian (Native American) or Alaska Native

Date of Service	Vax Type	Vaccine Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route	Injection Site	Date On VIS	Date VIS Given
	IIV4 (Flulaval)	GSK			0.5	Yes	Yes	IM	R Arm L Arm	8/7/15	Same as Consent Date

Signature of Vaccine Administrator: X_____

Provider Name: _____ **Public Schools** **MDPH Provider PIN#:** _ _ _ _ _

Provider Address: