



School _____

FLU IMMUNIZATION CONSENT FORM

Grade _____

Teacher _____

The Springfield School District, in cooperation with Jordan Valley Community Health Center is offering **Seasonal flu vaccine** to any child who qualifies for the **Vaccines for Children (VFC) Program**, as supply allows. If you would like your child to receive the flu vaccine, please complete this form. All vaccines given at these clinics are provided free of charge. **VACCINES OFFERED are Inhaled Intranasal Influenza (FluMist) or if contraindicated, Inactivated Influenza (FLU Shot)**

1) QUALIFYING CHILDREN for VFC: Check which applies for your child to receive **Seasonal flu vaccine** (at least one must apply).

_____ he/she has no insurance

_____ he/she has insurance, but it does not cover vaccinations

_____ he/she has Medicaid

_____ he/she is an Alaskan native or Native American

In addition, for those students with private insurance coverage that fully covers vaccinations and therefore not qualifying for VFC, a limited amount of vaccine has been provided by Cox Health and Mercy St John's and will be given free of charge as supply allows. Please check for your child to receive Seasonal Flu vaccine if available. ___ he/she **HAS** private insurance (not Medicaid) that pays fully for vaccinations

We have attached Vaccine Information Sheets for each of the vaccines. If you have questions about the vaccines that cannot be answered by the attached Vaccine Information Sheets, please talk to your school nurse.

2) CHILD'S INFORMATION:

Child's Name: _____ SS# _____ Gender: M F Race _____

Child's Date of Birth: _____ Medicaid No: _____ Language: _____

Child's Mother/Father/Guardian Name: _____ Date of Birth: _____ Phone: _____

Child's Street Address: _____ City _____ Zip: _____

3) PLEASE CIRCLE 'YES' OR 'NO'

1. Has your child received a vaccine within the past 30 days? Yes No
If yes, please list name of vaccine(s): _____

2. Has your child received a flu vaccination before? Yes No

3. Is your child allergic to any part of the vaccine (eggs, egg proteins, gentamicin, gelatin, or arginine)? Yes No

4. Has the child ever had a life-threatening reaction to an influenza vaccine? Yes No

5. Is your child currently receiving aspirin or aspirin-containing therapy? Yes No

6. Does your child have asthma, recurrent wheezing, or active wheezing? Yes No

7. Has your child ever had Guillain-Barré syndrome? Yes No

8. Does your child have any diseases (for example, cancer, lupus, or HIV/AIDS) or take a medication (for example, steroids or chemotherapy) that lowers the body's resistance to infection? Yes No

9. Does your child have any of the following long-term health problems? (CHECK CIRCLE)
o heart disease o kidney disease o metabolic diseases (for example, diabetes)
o other _____

10. Is your child pregnant or nursing? Yes No

11. Please let us know if your child has close contact with anyone who has a weakened immune system (for example, an individual who has had a bone marrow transplant and is in a negative pressure hospital room). Please describe: _____

Allergies/medical alert: _____

4) READ AND SIGN BELOW:

Request for administration of inactivated Influenza (FLU Shot) or inhaled Influenza for the above-named recipient: I have been given the CDC Vaccine Information Statement. I have read this document and have no further questions at this time. I understand that my child will receive the inhaled Influenza vaccine unless contraindicated, then my child will receive the inactivated Influenza (FLU shot) vaccine. I understand the risks and benefits of live intranasal influenza and the inactivated intramuscular influenza vaccines. I request and voluntarily consent that the vaccine be given to the above-named recipient, of whom I am the parent or legal guardian, and I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the side effects and warnings of the vaccine.

Signature of Parent/Guardian _____ Date _____

Office Use only

Date: _____ Name: _____ DOB: _____

_____ Inactivated Flu Vaccine (VIS – 07/26/11)

_____ FluMist (VIS – 07/26/11)

Vaccine	Mfr	Lot No	Exp Date	Site	Route	Person Adm.
FluMist	MedIm			IN	Nasal	
Inactivated Flu	S-P/NOV/GSK				IM	

Supervising Practitioner _____