

SEASONAL INFLUENZA VACCINE CONSENT FORM

The Springfield Public School District, in cooperation with Jordan Valley Community Health Center, and the Springfield Greene County Health Department, is offering the **Seasonal Influenza Vaccine** to all children FREE with parental consent. There are two vaccines available, the **Inactivated Influenza Vaccine (Shot)** and the **Inhaled Intranasal Influenza Vaccine (Flu-Mist)**, these will be given depending on availability and as indicated. If you would like your child to receive the **seasonal influenza vaccine**, please complete this form. All vaccines given at these clinics are provided free of charge.

School Name _____ Grade _____ Teacher _____

1) CHILD'S INFORMATION:

Name: _____ Date of Birth: _____

SSN _____ - _____ - _____ Gender: M F Race _____ Phone # _____

Street Address: _____ City: _____ Zip: _____

Mother/Father/Guardian Name: _____ Phone# _____

Has Insurance **Uninsured** **Medicaid (# _____)** **Alaskan native or Native American**

2) VACCINES OFFERED: Your child will receive FluMist unless contraindicated.

Inhaled Nasal (FluMist) Influenza Vaccine (Must be 2 years of age or older who **do not have** a chronic lung, heart, kidney, liver or metabolic disease, asthma, weak immune system, muscle or nerve disorder, blood disorders, on long term aspirin treatment or are pregnant)

Inactivated Influenza (Flu Shot) Vaccine (Yearly doses recommended, Must be 6 months of age or older)

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

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): _____ If Flu vaccine: MIST or SHOT Date received: _____ | | |
| 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) | | |
| ○ heart disease ○ kidney disease ○ metabolic diseases (for example, diabetes) | | |
| ○ 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 Vaccine (FLU Shot) or Inhaled Influenza Vaccine (FluMist) for the above-named recipient: I have been given the 2010-2011 Vaccine Information Statement. I have read this document and have no further questions at this time. I understand that my child will receive the Influenza vaccine that is available and as indicated. 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 _____

*****FOR OFFICE USE ONLY*****

Date: _____ Name: _____ DOB: _____

_____ Inactivated FLU VAC (VIS-08/10/10) _____ Inhaled FLU VAC (VIS-08/10/10)

Vaccine	Mfr	Lot No	Exp Date	Dose Number 1 or 2	Site	Route	Name and Title of Vaccine Administrator
FluMist	MI					<input type="checkbox"/> IN	
Inactivated						<input type="checkbox"/> IM	

VFC eligible: Yes _____ No _____

School site: _____