

St. Mary's County Health Department

SCHOOL INFLUENZA VACCINATION CONSENT FORM
(2009-2010 SCHOOL YEAR)

FOR SCHOOL NURSE USE ONLY: _____ LAIV _____ TIV _____ Needs Booster

Student's Last Name: _____ First Name: _____ MI: _____
 Address: _____ Zip Code: _____
 Telephone (Home): _____ (Work): _____
 D.O.B.: _____ Age: _____ Sex: _____ Race: _____ Ethnicity (circle): Hispanic / Non-Hispanic
 School: _____ Home Room/Grade: _____ Student ID#: _____

Please answer the following questions for your child being vaccinated.

Circle condition or explain.

		Check One	
		Yes	No
Medical History			
1.	Has your child ever had flu vaccine in previous years? (Children under 9 need a two-dose series the <u>first</u> year they get a flu vaccine, then 1 <u>dose yearly</u> thereafter.) If so, how many? <input type="checkbox"/> Never <input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> 3 or more		
2.	Has your child ever had a serious allergic reaction to flu vaccine?		
3.	Does your child have any serious allergies to medications (esp. neomycin, genamycin.), food (esp. eggs, egg products), vaccines, or any other allergies? List allergies _____ Read the Vaccine Information Sheet about vaccine ingredients.		
4.	Does your child have a chronic health problem such as: [heart disease, metabolic disease (like diabetes), kidneys or lungs (like asthma or cystic fibrosis), nervous system, seizures, the brain, or blood system (like sickle cell anemia)]? Other: _____		
5.	Has a health care provider said that your child was wheezing or has asthma?		
6.	Does your child have cancer, leukemia, AIDS, or any other immune system problem, including the removal of the spleen?		
7.	Has your child used a nebulizer, taken cortisone, prednisone, other steroids, <u>nose sprays</u> , or anticancer drugs or x-ray treatments? When? _____		
8.	Is your child taking medicine containing aspirin? Drug/Dose: _____		
9.	Has your child had Guillian-Barre syndrome (a temporary ascending paralysis)?		
10.	Has your child receive any vaccines in the past 4 weeks or is your child due for any in the month following this vaccine(s)? If so, what vaccine(s)? _____		
11.	Does your child live with someone with a weakened immune system who has to be in a protective environment (a hospital room with reverse airflow)?		
12.	Has your child had a blood transfusion or blood products or immune (gamma) globulin?		
13.	For females: Is the child pregnant or planning pregnancy in the next month?		

If your child is sick on influenza (flu) vaccination day with a fever, the vaccine cannot be given.

Statement of Consent:

"I have read and understand the Vaccine Information Statement(s) (VIS) which I received. I have had the chance to ask any questions I had about the vaccine(s). I agree to have my medical information recorded electronically. I was offered a copy of the Notice of Privacy Practice with an effective date of 4/14/03."

Name of Child (print): _____ Relationship to Child: _____

Signature of Parent/Child if 18: _____ Date: _____

NO THANK YOU. I do not wish (for my child) to receive the influenza vaccination. (sign)

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 For Clinic/Office Use: Clinic Address/Date: SMCHD - _____

Influenza Vaccine	Date Administered	by	
Flumist/ Medimmune Lot # _____	Exp _____ VIS 08/11/09	nasal	Fluzone/ Sanofi Pasteur Lot # _____ Exp _____ VIS 08/11/09
			RA or LA IM

