

2011 Influenza Vaccine School Consent Form

Polk County Health Department

FOR OFFICE USE	
VFC-Nasal	VFC-IM
Private-Nasal	Private-IM

STUDENT'S NAME (Last)	(First)	(M.I.)	GRADE	TEACHER	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	STUDENT'S BIRTH DATE (m/d/y)	AGE	GENDER M / F
ADDRESS			PARENT/GUARDIAN DAYTIME PHONE NUMBER:		
CITY	STATE	ZIP	SCHOOL		

Please answer the following questions by circling "YES" or "NO". We need this important health information to determine if your child should receive this vaccine.

1. Does your child have a serious allergy to eggs?	YES	NO
2. Does your child have any other serious allergies? Please list: _____	YES	NO
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	YES	NO
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO

There are two kinds of 2011-2012 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine your child can get. (Please circle "YES" or "NO")

1. Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? If yes, please indicate type and date. Vaccine: _____ Date given: month _____ day _____ year _____	YES	NO
2. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? Please list: _____	YES	NO
3. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	YES	NO
4. Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	YES	NO
5. Is your child pregnant?	YES	NO
6. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	YES	NO
7. Did your child receive influenza vaccine last year? If yes, circle how many doses your child received?	YES	NO
8. Do you prefer your child get one type of vaccine over another? If "YES" check which kind of vaccine below that you want your child to receive. Your child may not receive this preferred vaccine if he/she has a medical contraindication or if that vaccine is unavailable. _____ Flu Mist (intranasal) _____ Inject able (Intramuscular)	YES	NO

Please circle "YES" or "NO" for each consent item and sign below. Your child will not receive influenza vaccination without a parent or guardian signature.

1. I have read the 2011-12 Vaccine Information Statement for the influenza vaccine and understand the risks and benefits. This consent allows for the Polk County Health Department to administer influenza vaccine to the child listed above.	YES	NO
2. I consent to sharing influenza immunization data with the Wisconsin Immunization Registry (WIR) so that my clinic/physician is aware that my child received this vaccine.	YES	NO
3. If my child is covered by WEA or Health Partners health insurance, I consent to allow the Polk County Health Department to bill my insurance company for the administration of influenza vaccine. Do not complete if your child is not covered by either of these plans. Please Circle Health Insurance: WEA Health Partners Group # _____ ID# _____ Subscriber's Name _____	YES	NO

Parent or Guardian Signature: _____ Date: _____

FOR ADMINISTRATIVE USE ONLY

Dose	Date Dose Administered	Route	IM Site	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
1		<input type="checkbox"/> IM <input type="checkbox"/> Intranasal	<input type="checkbox"/> LD <input type="checkbox"/> RD			
2		<input type="checkbox"/> IM <input type="checkbox"/> Intranasal	<input type="checkbox"/> LD <input type="checkbox"/> RD			