2017-2018
NEW HAMPSHIRE SEASONAL INFLUENZA SCHOOL VACCINATION CONSENT FORM

SCHOOL NAME SAU#	CITY	GRADE

SECTION 1: DEMOGRAPHICS

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 Male ☐ Female ☐
Address	Medical Insurer		Parent/Guardian Daytime Phone Number:	
City	State	Zip		

If you want vaccination information sent to your child's medical provider, please provide the following: ➡

Medical Provider Name: ____________________________________
Office Name: ____
Address:
____
____
Phone: ________________________ Fax: _____________________

SECTION 2: SCREENING FOR VFC ELIGIBILITY *PLEASE NOTE STUDENTS ARE ELIGIBLE TO RECEIVE VACCINE FOR FREE

Please check the appropriate box	**YES**	**NO**
1. Is your child enrolled in Medicaid?		
2. Is your child uninsured?		
3. Is your child insured with private insurance?		
4. Is your child American Indian or Alaska Native?		

SECTION 3: SCREENING FOR VACCINE ELIGIBILITY

A. ***If you answer "YES" to any of the questions below your child <u>cannot</u> get vaccinated at school. Contact your child's doctor to discuss other options.***	**YES**	**NO**
1. Does your child have a serious allergy to eggs or any part of the influenza vaccine?	☐	☐
2. Has your child ever had a serious reaction to a previous dose of flu or other vaccine?	☐	☐
3. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) after receiving vaccine?	☐	☐
4. Is your child pregnant?	☐	☐
	☐	☐

SECTION 4: CONSENT FOR CHILD'S VACCINATION IN SCHOOL

I have answered **NO** to the questions in Section 3 (1-5). I have reviewed the CDC Injectable Influenza Vaccine Information Statement dated 8/07/2015. I understand the benefits and risks of the vaccine and ask that the influenza vaccine be given to the student named above for whom I am authorized to make this request. I agree to release the School District from all liability related to any adverse reaction to the vaccine.

☐ **Yes**, I **DO** want my child vaccinated with the influenza vaccine at school.

***Signature of Parent/Legal Guardian** ____ Date: ___________

***REQUIRED**

SECTION 5: FOR ADMINISTRATIVE USE ONLY VIS Date: 08/07/2015
Is the student sick with a fever today? ☐ No ☐ Yes If yes, do not give vaccine.

Vaccine	Date Dose Given	Route	Manufacturer	Lot # Expiration Date	Name and Title of Vaccine Administrator
Fluarix®_____		☐ IM -deltoid L __ R__	GlaxoSmithKline	DT2S7 06/30/2018	