Annual Influenza Vaccine Consent Form-FLU SHOT and NASAL SPRAY

Section 1: Information about Child to Receive Vaccine (please print)

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** M / F
ADDRESS				**PARENT/GUARDIAN DAYTIME PHONE NUMBER:**	
CITY	**STATE**	**ZIP**			
STUDENT'S DOCTOR'S NAME (Last, First)		**Address**		**City**	**Zip**
SCHOOL NAME **POPE JOHN PAUL THE 2ND HIGH SCHOOL**				**GRADE**	

Section 2: Screening for Vaccine Eligibility

Please mark YES or NO for each question.

Has your child been vaccinated with the seasonal influenza vaccine after July 1, 2010? YES ☐ NO ☐

The following four questions will help us to know if your child can get the intranasal influenza vaccine. If you answer "NO" to all of them, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following questions, your child may be able to get the seasonal influenza vaccine, but we will contact you to discuss your options.	**YES**	**NO**
1. Does your child have a serious allergy to eggs?	☐	☐
2. Does your child have any other serious allergies? Please list: _____	☐	☐
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐
There are two kinds of seasonal influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine your child can get.		
1. Has your child gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month_____day_____year_____	☐	☐
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?	☐	☐
3. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	☐	☐
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)?	☐	☐
5. Is your child pregnant?	☐	☐
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)?	☐	☐

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:

I have read or had explained to me the 2015-2016 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

☐ **I GIVE CONSENT** to the Goodlettsville Pediatrics and its staff for my child named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then you child will not be vaccinated)

☐ **I DO NOT GIVE CONSENT** to the Goodlettsville Pediatrics and its staff for my child named at the top of this form to be vaccinated with this vaccine.

Signature of Parent/Legal Guardian _____ Date: month_____day_____year_____

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
Influenza	☐ IM ☐ Intranasal	/ /			