2018- 2019 INFLUENZA VACCINE CONSENT,
Childhood Vaccine Insurance Information AND SCREENING FORM
Injectable (Flu Shot)

Section 1: Information about the student to receive vaccine (please print): *Required Fields

Name: (Last, First, MI)*	Date of birth: * _____ ____ _____ Month Day Year	Age *	Sex: (Circle) * Male Female
Street Address:		Student grade:	
City:	State:	Zip:	Phone: ( )

Section 2: Consent for Vaccination

CONSENT FOR CHILD'S VACCINATION: I have read or had explained to me the 2015-2016 (no change for 2018-2019) Vaccine Information Statement for the influenza vaccine and understand the risks and benefits.

I GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine. (If this consent is not signed, dated and returned, my child will not be vaccinated.)	**I DO NOT GIVE CONSENT** for my child named at the top of this form to get vaccinated with this vaccine.
_____ ____/____/____ **Signature of Parent/ Legal Guardian Date**	_____ ____/____/____ **Signature of Parent/ Legal Guardian Date**

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:	Member ID Number:	Group ID Number: (if available)

If person getting vaccinated is not the subscriber, please complete the following:

Subscriber's Name: (Last, First, MI)	Subscriber's Date of Birth: * _____ ____ _____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address: (If different from address above)		
City:	State:	Zip:	Phone: ( )
Patient Relationship to Subscriber: (Circle)* Child Other		

I give permission for my insurance company to be billed. I also give permission for my child's vaccination information be entered into the Massachusetts Immunization Information System.

*** _____ Date: _____
(Signature of parent or legal guardian)

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***Attach Photo Copy of All Insurance Cards (If able to)**

For children 18 years of age and younger:

Is Vaccine for Children (VFC) Program eligible:
- ☐ Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
- ☐ Does not have health insurance
- ☐ Is American Indian (Native American) or Alaska Native

Is not VFC-eligible:
- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

Provider Name: Worcester Public Schools Nursing
Provider Address: 768 Main Street, Worcester, MA 01608

MDPH Provider PIN#: 14406

Screening for *Injectable (Flu Shot)*

Complete this side only if you consent to have your child receive flu vaccine. Answering these questions will help us to know whether your child will need 0, 1 or 2 doses of flu vaccine this year.

Section 1: Information to determine if your child should receive 0, 1 or 2 doses of flu vaccine

*Required Fields

If your child is 9 years old or older, go to Section 2 below.

If your child is 8 years old or younger, answer the other questions in this box.

1. Did your child receive 1 or more doses between July 1, 2017 and June 30, 2018? ☐ Yes ☐ No
2. If no, did your child receive 2 or more doses between July 1, 2010 and June 30, 2018? ☐ Yes ☐ No
3. Has your child received flu vaccine this flu season (since July 1, 2018)? ☐ **No (If no, go to Section 2)** ☐ **Yes**

   If yes, please tell us the number of doses and dates of vaccination: ☐ 1 dose ☐ 2 doses

   Dose 1: Date received: month ____ day ____ 2018 **Dose 2:** Date received: month ____ day ____ 2018

*Section 2: Information to determine if your child should receive the 2017-2018 flu vaccine

A. Please check YES or NO for each question. If you answer "YES" to one or more of the 4 questions, your child will not be able to get flu vaccine in school unless there is a note from your child's health care provider saying it is okay for your child to get flu vaccine. If you answer "NO" to all these questions, your child will receive the vaccine. If you are not sure of the answers, please check with your child's healthcare provider.

	NO	YES
1. Does your child have an allergy to eggs?		
2. Does your child have an allergy to gentamicin, neomycin, polymixin or gelatin?		
3. Has your child ever had a serious reaction to a flu vaccine in the past?		
4. Has your child ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

Date of Service *PLEASE FILL IN DATE	Vax Type	Vaccine Mfgr.	Lot No.	Exp. Date	Dose (mL)	State Supplied	Preserv. Free*	Injection Route	Injection Site (Circle)	Date On VIS	Date VIS Given
*	IIV4	Flulaval GSK			0.5	Yes	Yes	IM	R Arm L Arm R Leg L Leg	8/7/15	

IIV4 = Inactivated influenza vaccine, quadrivalent

***Signature of Vaccine Administrator:**

_____

***Print Name:**

_____

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