2020- 2021 WPS 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

Homeroom/Teacher:*	Grade: *		
Name: (Last, First, MI)*	Date of birth: * ______ _____ ______ Month Day Year	Age: *	Sex: (Circle) * Male Female

Race/Ethnicity: (check all that apply)	Where did student get flu vaccine **last year** (2019-2020 school year)?
◻ African American or Black	◻ Did not get flu vaccine
◻ American Indian, Alaska Native, Indigenous, or First Nations	◻ At school flu clinic in October
◻ Arab or Middle Eastern	◻ At school-based health center
◻ Asian or Asian American	◻ At pediatrician's office
◻ Hispanic, Latina, or Latino	◻ At pharmacy (ex. Walgreens, CVS, etc)
◻ Native Hawaiian or Pacific Islander	◻ Other: ______________________
◻ White, Caucasian, or European American	
◻ Other: ______________________	

Section 2: Consent for Vaccination

CONSENT FOR CHILD'S VACCINATION: I have read or had explained to me the 2019-2020 (no change for 2020-2021) Vaccine Information Statement for the influenza vaccine and understand the risks and benefits.

I GIVE CONSENT for vaccine administration, for my insurance company to be billed and entry/sharing of this information in the Massachusetts Immunization Information System (MIIS). *(If this consent is not signed, dated and returned, my child will not be vaccinated.)* ____________________________ ____/____/____ **Signature of Parent/ Legal Guardian Date**	**I DO NOT GIVE CONSENT** for my child named at the top of this form to be vaccinated with this vaccine. ____________________________ ____/____/____ **Signature of Parent/ Legal Guardian Date**

Section 3: Insurance Information

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
Patient Relationship to Subscriber: (Circle)* Child Other		

***Attach photo copy of insurance card (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 MDPH Provider PIN#: 14406
Provider Address: 768 Main Street, Worcester, MA 01608

Screening for Injectable Flu Vaccine (Shot)

Section 4: Complete this side only if you consent to have your child receive the flu vaccine.

*Required Fields

Answering these questions will help us to know whether your child will need 0, 1 or 2 doses of flu vaccine this year

If your child is 9 years old or older, go to Section 5 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, 2019 and June 30, 2020? ☐ Yes ☐ No

2. If no, did your child receive 2 or more doses between July 1, 2010 and June 30, 2020? ☐ Yes ☐ No

3. Has your child received flu vaccine this flu season (since July 1, 2020)? ☐ **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 ____ 2020 **Dose 2:** Date received: month ____ day ____ 2020

Section 5: Information to determine if your child should receive the 2020-2021 flu vaccine

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 the 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 the 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.

*Required Fields	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? *		

FOR OFFICE USE ONLY:

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	8/15/19	

IIV4 = Inactivated influenza vaccine, quadrivalent

***Signature of Vaccine Administrator:** ______________________________

***Print Name:** ___________________________________

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