

**2021- 2022 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) <input type="checkbox"/> African American or Black <input type="checkbox"/> American Indian, Alaska Native, Indigenous, or First Nations <input type="checkbox"/> Arab or Middle Eastern <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Hispanic, Latina, or Latino <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White, Caucasian, or European American <input type="checkbox"/> Other: _____		Where did student get flu vaccine <b>last year</b> (2020-2021 school year)? <input type="checkbox"/> Did not get flu vaccine <input type="checkbox"/> At school flu clinic in October <input type="checkbox"/> At school-based health center <input type="checkbox"/> At pediatrician's office <input type="checkbox"/> At pharmacy (ex. Walgreens, CVS, etc) <input type="checkbox"/> Other: _____	

**Section 2: Consent for Vaccination**

**CONSENT FOR CHILD'S VACCINATION:** I have read or had explained to me the 8/6/2021 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.)*

**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**

\_\_\_\_\_  
**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: <input type="checkbox"/> Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid) <input type="checkbox"/> Does not have health insurance <input type="checkbox"/> Is American Indian (Native American) or Alaska Native Is not VFC-eligible: <input type="checkbox"/> Has health insurance and is not American Indian (Native American) or Alaska Native
--

## 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, 2020 and June 30, 2021?  Yes  No
2. If no, did your child receive 2 or more doses between July 1, 2010 and June 30, 2021?  Yes  No
3. Has your child received the flu vaccine this flu season (since July 1, 2021)?  **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 \_\_\_\_ 2021    **Dose 2:** Date received: month \_\_\_\_ day \_\_\_\_ 2021

### Section 5: Information to determine if your child should receive the 2021-2022 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	Vax Type	Vaccine Mfr.	Lot No.	Exp. Date	Dose (mL)	State Supplied	Preser v. Free*	Injection Route	Injection Site (Circle)	Date On VIS	Date VIS Given
*PLEASE FILL IN DATE					0.5	Yes	Yes	IM	R Arm L Arm R Leg L Leg	8/6/21	

IIV4 = Inactivated influenza vaccine, quadrivalent

**\*Signature of Vaccine Administrator:**

**\*Print Name:**