Influenza Vaccination Clinic Consent Form-Student

MUST FILL OUT ALL AREAS OF THIS FORM IN ORDER TO RECEIVE VACCINE

Information About Child to Receive Vaccine: *(Please print)*

Child's Name – Last:	First:	M.I.
Child's Date of Birth: Month _____ Day _____ Year _____	Child's Gender (circle) Male / Female	
Child's Doctor's Name/Clinic:		
Grade:	Teacher:	

Parent/Legal Guardian's Name – Last:	First:	M.I.
Address:		
City:	State:	Zip:

Screening for Vaccine Eligibility ***Please mark YES or NO for each question.***

The answers to the following questions will help us to determine if your child can be vaccinated:	***YES***	***NO***
Does your child have an active illness or fever today? *Monitor for any illness and notify the school.*	☐	☐
Has your child had a serious reaction to an influenza vaccination?	☐	☐
Does your child have any of the following? Heart disease, lung disease, kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or have a cochlear implant or spinal fluid leak, or no spleen.	☐	☐
Does your child have a weakened immune system?	☐	☐
Is your child receiving or recently received influenza antiviral medications?		
Is your child on long-term aspirin treatment?	☐	☐
Is your child pregnant or could they become pregnant in the next month?	☐	☐
Has your child ever had Guillain-Barre syndrome?	☐	☐
Does your child live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation?	☐	☐
Has your child received any live virus vaccinations, i.e. MMR, chicken pox, in the past 4 weeks?	☐	☐

Insurance Information

Insurance Company Name:		Subscriber's/Policy Holder's Name:
Insurance Claims Address:		Subscriber's/Policy Holder's Date of Birth:
ID Number:	Policy or Group Number:	Subscriber's/Policy Holder's Phone Number:
Medical Assistance Number:		

Minnesota Vaccines for Children Program MnVFC Screening: MnVFC Eligibility Criteria. Please √ only one box.	
	Uninsured
	Enrolled in MN Healthcare Program (MA, PMAP, GAMC, MnCare)[1]
	American Indian or Alaskan Native
	None of the above

***I prefer for my child to receive the (must select one): _____Injection (Shot) OR _____ Nasal Spray**

Consent for Child's Vaccination:

I have read or had explained to me the **Influenza** Vaccine Information Statement for the influenza vaccine and understand the risks and benefits. **I give consent** to CentraCare for my child named at the top of this form to be vaccinated with this vaccine.

***Your signature on the Admission Consent is required to vaccinate your child.**

*****STAFF USE ONLY								
Vaccine	**Date Dose Administered**	**Injection Site**	**Lot Number**		**Vaccine**	**Date Dose Administered**	**Injection Site**	**Lot Number**
FluLaval					Flumist			