School-Located Flu Vaccination Consent Form

Last Name *(Please print)*	First Name	MI	Age	Date of Birth	☐ Male ☐ Female
				____/____/_____	

Address	City	State	Zip

Phone Number	Email

If student, print name of school he/she attends:	Grade

Health Insurance Information

Indicate insurance provider and subscriber number. Please include all letters/numbers.

☐ Blue Cross & Blue Shield ID# _____ ☐ Tufts or Tufts/Carelink_____

☐ Neighborhood Health Plan of RI _____ ☐ Neighborhood Health Plan of MA_____

☐ UnitedHealthcare ID# _____ Group # _____ ☐ Aetna_____

☐ Medicare _____ ☐ Other Insurance _____ ☐ No Insurance

(Insurance Name & ID Number)

Screening for Flu Vaccine Eligibility

If you answer "YES" to any question 1-4, we cannot vaccinate at school. Please contact your doctor to discuss options.

1. Any serious allergy to eggs?	Yes	No
2. Ever had a serious reaction to a previous dose of flu vaccine that required medical attention?	Yes	No
3. Ever had Guillain-Barre Syndrome (temporary severe muscle weakness) after receiving flu vaccine?	Yes	No
4. Any allergy to Thimerosal or Latex?	Yes	No

Answer the following questions <u>ONLY</u> if intranasal (FluMist) is preferred (available to ages 3-18 years).

5. Received any vaccines (not just flu) within the past 30 days?	Yes	No
6. Have asthma, diabetes, or disease of the lungs, heart, kidneys, liver, nerves, or blood?	Yes	No
7. On long-term aspirin or aspirin-containing therapy (aspirin every day)?	Yes	No
8. Have a weak immune system from HIV, cancer, or medications such as steroids or those used to treat cancer, or are in close contact with a person who needs care in a protected environment?	Yes	No

Consent for Vaccination in the School Setting

Please check one:

☐ Only injectable flu vaccine may be administered.

☐ Only FluMist (intranasal) vaccine may be administered.

☐ FluMist (intranasal) vaccine is preferred, but injectable flu vaccine may be administered if only injectable flu vaccine is available.

I have answered "No" to questions 1-4. I have viewed the Vaccine Information Statement(s) at www.immunize.org or viewed a hard copy obtained by calling the Rhode Island Department of Health (401-222-5960). I understand the benefits and risks of the vaccine.

The vaccine checked above should be given to the person named above for whom I am authorized to make this request. I understand that I can review a *Notice of Privacy Practice* at the time of vaccination.

I hereby release *The Wellness Company Inc.* from any and all liability associated with the administration and potential side effects of the vaccine.

Signature of Parent/Guardian/Patient _____ Date _____

(Please print) Last name _____ First name _____

FOR ADMINISTRATIVE USE ONLY **VIS Date: 8/7/2015**

Vaccine	Route	Manufacturer	Lot No.	Date VIS Given	Date Vaccine Given	Signature of Vaccine Administrator
Influenza	***IM*** *R L* *Intranasal*					