Influenza Vaccination Consent Form

Please complete and return this form (PLEASE PRINT).

Name of child receiving vaccination: ______________________________ Birth date: __________

Address: ____

City: ____________________ State: ____________________ ZIP Code: __________

Home telephone: ____________________ Emergency contact number: ____________________

Mother's name: ____________________ Father's name: ____________________

Grade: ______________ Homeroom Teacher's Name: ______________________________

Please circle YES or NO to the questions below:

1. Is your child allergic to eggs, egg proteins, or to another component of influenza vaccines? Yes No
2. Has your child ever had a serious reaction to an influenza vaccine? Yes No
3. Has your child ever had Guillain-Barŕe syndrome? Yes No
4. Is your child younger than 2 years of age? Yes No
5. Does your child have asthma or recurrent or active wheezing? Yes No
6. Is your child under 18 years of age currently receiving aspirin or aspirin containing therapy? Yes No
7. Does your child have any diseases (e.g., cancer, lupus, or human immunodeficiency virus [HIV] or acquired immunodeficiency syndrome [AIDS]) or take a medication (e.g., steroids or chemotherapy) that lowers the body's resistance to infection? Yes No
8. Has your child received a vaccine within the past 30 days? Yes No
   If yes, please list name of vaccine(s): ____________________ Date__________
9. Does your child have any of the following long-term health problems? (PLEASE CIRCLE)
   heart disease lung disease kidney disease metabolic diseases (eg, diabetes)
   other ______________________________
10. Is your child pregnant or nursing? Yes No
11. Please let us know if your child has close contact with anyone who has a weakened immune system and must be in a protective environment (eg, an individual who has had a bone marrow transplant). Please describe:
    ____

Note: If you answered YES to questions 1, 2, or 3, your child should NOT receive an influenza vaccine through the school vaccination program. If you answered YES or left blank any of the questions 4 through 11, your child should NOT receive an intranasal influenza vaccine, but is recommended to receive an injectable influenza vaccine.

I have been given the Centers for Disease Control and Prevention Vaccine Information Sheets. I have read these documents and have no further questions at this time. I understand the risks and benefits of both vaccines. I request and voluntarily consent that influenza vaccine be given to ______________________________ of whom I am the parent or legal guardian, and I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the possible side effects and warnings and precautions that should be taken into consideration prior to administration of the vaccine.

Allergies or medical alert: ____

Please note: We will not know the type of vaccine that is being shipped to us until the day of delivery.

My preference for my child's influenza vaccine is the following:

☐ Inactivated injectable influenza vaccine ONLY

☐ Live intranasal influenza vaccine ONLY

☐ Either injectable influenza vaccine OR live intranasal influenza vaccine

Print Name of parent: ____________________ Signature of Parent or Legal Guardian: ____________________

Date: ________