

## 2017-2018 Seasonal Influenza Vaccination Consent Form

**Please complete and return this form to the School Secretary by September 29, 2017**  
**If you have questions, please contact Hodgeman County Health Department**  
**Courthouse, Jetmore, KS 67854 at 620- 357- 8736.**  
**(PLEASE PRINT)**

Name of child receiving vaccination: \_\_\_\_\_  
LAST FIRST DATE OF BIRTH

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_ Parent/Guardian Date of Birth: \_\_\_\_\_

Student's Grade: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

1. Has your child received a vaccine within the past 4 weeks? If yes, please list name of vaccine(s): _____	Yes	No
2a. How old is your child? _____ <b>For children 8 yrs &amp; less:</b>		
<b>Has your child has received 2 or more doses of flu vaccine prior July 1, 2015</b> <b>If no, your child will be given 2 doses of flu vaccine 4 weeks apart.</b>	<b>Yes</b>	<b>No</b>
3. Is your child allergic to any part of the vaccine (ex: eggs, gentamicin, gelatin, or thimerosal)?	Yes	No
4. Has the child ever had a life-threatening reaction to an influenza vaccine?	Yes	No
5. Has your child ever had Guillain-Barré syndrome?	Yes	No
6. Is your child currently receiving aspirin or aspirin-containing therapy?	Yes	No
7. Is your child receiving influenza antiviral medications?	Yes	No
8. Does your child have asthma, recurrent wheezing, or active wheezing?	Yes	No
9. Does your child have any diseases (for example, cancer, lupus, or HIV/AIDS) or take a medication (for example, steroids or chemotherapy) that lowers the body's resistance to infection?	Yes	No
10. Does your child have any of the following long-term health problems? (CHECK CIRCLE) <input type="radio"/> heart disease <input type="radio"/> kidney disease <input type="radio"/> metabolic diseases (for example, diabetes) <input type="radio"/> seizure disorder <input type="radio"/> other _____		
11. Is your child pregnant?	Yes	No
12. Does your child have close contact with anyone who has a weakened immune system (For example, an individual who has had a bone marrow transplant and is in protective isolation).	Yes	No

**Consent for administration of Influenza Vaccine:** I have been offered a copy of the Influenza Vaccine Information Statement(s) (VIS) (dated 8-07-15). I have read, had explained to me, and understand the information in the VIS. I ask that the Influenza vaccine be given to the person named above for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry on behalf of the person named above.

Mark the box if you prefer your child to have the **Flu Shot** instead of FluMist.

**Signature of parent/guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>Please Mark Appropriate Box</b>	<b>PATIENT ELIGIBILITY</b>	
<input type="checkbox"/> KanCare (T19/ 21) <input type="checkbox"/> Underinsured <input type="checkbox"/> Underserved <input type="checkbox"/> No Health insurance <input type="checkbox"/> Native AM/Alaska Native <input type="checkbox"/> Fully Insured		

**FOR ADMINISTRATION PERSONNEL ONLY**

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the VIS date, manufacturer, lot #, and expiration date)

**For Clinical Use Only**

VACCINE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER LOT #	EXP DATE
Influenza, LAIV			0.1 ml intranasal each nostril			
Influenza, Inactivated	RT      LT	Deltoid  Vastus Lat	IM	8-7-15		

\_\_\_\_\_  
Signature and Title of Vaccine Administrator\_\_\_\_\_  
Date**FOR ADMINISTRATION PERSONNEL ONLY**

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the VIS date, manufacturer, lot #, and expiration date)

**For Clinical Use Only**

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\_\_\_\_\_  
Signature and Title of Vaccine Administrator\_\_\_\_\_  
Date