# Seasonal Influenza Vaccination Consent Form

**Please complete and return this form to the School Secretary**
**If you have questions, please contact Hodgeman County Health Department**
**309 Main, 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: _____

Insured name: _____ Insured Date of Birth:_____

Student's Grade:_____ Primary Care Physician:_____

| | |
|---|---|
| 1. Is your child allergic to any part of the vaccine (ex: eggs, gentamicin, gelatin, or thimerosal)? | Yes No |
| 2. Has the child ever had a life-threatening reaction to an influenza vaccine? | Yes No |
| 3. Has your child ever had Guillain-Barré syndrome? | Yes No |
| 4. Is your child currently receiving aspirin or aspirin-containing therapy? | Yes No |
| 5. Is your child receiving influenza antiviral medications? | Yes No |
| 6. Does your child have asthma, recurrent wheezing, or active wheezing? | Yes No |
| 7. 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 |
| 8. Does your child have any of the following long-term health problems? (CHECK CIRCLE)<br>○ heart disease ○ kidney disease ○ metabolic diseases (for example, diabetes)<br>○seizure disorder ○ other_____ | |
| 9. Is your child pregnant? | Yes No |
| 10. Does your child have close contact with anyone who has a weakened immune system<br>(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) and notice of privacy practice. 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. I am aware that I am responsible for providing insurance information and if insurance doesn't cover, I am responsible for payment.

Mark the box of your preference

Flu shot □ Flu Mist □ No Preference □

**Signature of parent/guardian**: _____**Date**:_____

**Please Mark Appropriate Box** **PATIENT ELIGIBILITY**
_____KanCare (T19/ 21) _____Underinsured _____Underserved _____No Health insurance _____Native AM/Alaska Native ___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 | | | |

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 | | | | | | |
|---|---|---|---|---|---|---|
| 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 | | | |

Signature and Title of Vaccine Administrator

Date