School-Located Flu Vaccination Consent Form

Last Name *(PRINT- BLACK INK only)*	First Name	MI	Age	Date of Birth	☐ Male ☐ Female
				____/____/_____	

Address	City	State	Zip

Phone Number	Email

Health Insurance Information

Indicate insurance provider and subscriber number. Include all letters and numbers.

☐ Blue Cross & Blue Shield _____

☐ Neighborhood Health Plan _____

☐ UnitedHealthcare ID# _____ Group # _____

☐ Medicare _____

☐ Other Insurance _____

☐ Tufts or Tufts/Carelink_____

☐ TriCare_____

☐ Aetna_____

☐ No Insurance

Screening for Flu Vaccine Eligibility

If you answer "YES" to any of these questions, we cannot vaccinate at school. 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. Is there a possibility that the person receiving the vaccine is pregnant?	Yes	No
Answer the following questions <u>ONLY</u> if intranasal (FluMist) is preferred (available to ages 3-18 years).		
5. Received the MMR and/or Varicella vaccine(s) within the past 30 days or any other live vaccine?	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 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: 0 8 / 0 7 / 2 0 1 5**

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