

Influenza Vaccine Child Consent Form

Section 1: Information about Child to Receive Vaccine (please print)

CHILD'S NAME (Last)	(First)	(M.I.)	CHILD'S DATE OF BIRTH	
			month _____ day _____ year _____	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	CHILD'S AGE	CHILD'S GENDER M F
ADDRESS	PHONE NUMBER		► Insurance/Eligibility Status—Check all that apply ◀ <input type="checkbox"/> Insured, Vaccines Covered <input type="checkbox"/> Insured, Vaccines Not Covered <input type="checkbox"/> Badger Care <input type="checkbox"/> No Health Insurance <input type="checkbox"/> Medicaid Eligible <input type="checkbox"/> Native American	
CITY	STATE	ZIP		

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if your child can get the seasonal influenza vaccine and which kind they can receive. Please mark YES or NO for each question.

	YES	NO
1. Is your child sick today?		
2. Does your child have an allergy to eggs, gentamicin, gelatin or other component of the influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child have any other serious allergies? Please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your child ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is your child younger than age 2 or older than 18 years of age?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child have a long-term health problem with heart disease, lung disease, <u>asthma</u> , kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g. diabetes), anemia, or other blood disorder?		
8. If the child to be vaccinated is a child ages 2 through 4 years in the past 12 months, has a health care provider ever told you that he or she had wheezing or asthma.		
9. Does your child have a weakened immune system because of HIV/AIDS or other disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with x-ray or drugs?		
►► 10. Has your child received any other vaccinations in the past 4 weeks? (e.g. MMR, Chicken Pox or nasal FLUMIST ◀◀ Vaccine: _____ Date given: Month _____ Day _____ Year _____	<input type="checkbox"/>	<input type="checkbox"/>
11. Is your child currently receiving antiviral medications, Tamiflu (oseltamivir) or Relenza (zanamivir), in the past 48 hours?	<input type="checkbox"/>	<input type="checkbox"/>
12. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	<input type="checkbox"/>	<input type="checkbox"/>
13. (Girls only) Is your daughter pregnant or could she become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does your child live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as a hospital room with reverse air flow or someone who has recently had a bone marrow transplant)?	<input type="checkbox"/>	<input type="checkbox"/>

Section 3: Consent

<p>CONSENT FOR CHILD'S VACCINATION:</p> <p>I have read or had explained to me the 2011-2012 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.</p> <p>I GIVE CONSENT to the STATE/LOCAL health department and its staff for my child named at the top of this form to be vaccinated with this vaccine and . (If this consent form is not signed, dated, and returned, then your child will not be vaccinated at school) and entry into WIR.</p> <p>Signature of Parent/Legal Guardian _____ Date: _____</p>

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Site	Dose # (1st or 2nd)	Vaccine Manufacturer	Lot Number	Signature and Title of Vaccine Administrator
Influenza	/ /11	<input type="checkbox"/> IM <input type="checkbox"/> Intranasal	LV RV LD RD		Medimmune Medimmune Sanofi Pasteur Sanofi Pasteur	Mist 501105P Mist 501111P Injectable UH442AB Fluzone, P-free UT4114BA	