ALAMEDA COUNTY IMMUNIZATION PROGRAM
PUBLIC HEALTH DEPARTMENT
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Flu Vaccination Screening and Consent Form
Say "Boo" to the Flu -- Castro Valley Unified School District

Please complete this form and return it to your child's school office to receive a flu vaccine on-site. Thank you. If you do not want your child to receive a flu vaccine at school, do not complete or return this form.

PATIENT INFORMATION

Last Name:_____ First Name:_____ Date of Birth: ____/___/___

Street Address:_____ City:_____ Zip Code:_____

Mother's First Name: _____ Phone: _____ Teacher/Rm#_____ Gender M ☐ F ☐

PARENT/GUARDIAN CONSENT REQUIRED

CONSENT: I give permission for my child to receive flu vaccine while at school. I have read or have had explained to me the information in the Vaccine Information Statement(s) (VIS). I understand the benefits and risks of the flu vaccine.

☐ **Yes, I consent. I would like my child to receive a flu vaccine at school without parent.**

☐ **Yes, I consent. Do not vaccinate until parent is present.**

Printed name of student/patient_____ **Date** _____

Signature of student/ patient_____ **Date** _____
(or parent/guardian if patient is under 18 years old)

Please answer **ALL** of the questions for your child/student, referred to as "the patient"

1. Does the patient have severe allergies to:
   - Eggs? ..... Yes ☐ No ☐
   - A vaccine component? (which? _____) ..... Yes ☐ No ☐
   - Latex?..... Yes ☐ No ☐

2. Has the patient had a serious reaction after receiving a vaccination? If yes, please describe: Yes ☐ No ☐
   _____

3. Does the patient have a history of heart disease, lung disease, kidney disease, metabolic disease (e.g., diabetes), anemia or on long term aspirin therapy, cancer, leukemia, AIDS or any other immune system problem? Please specify: _____ Yes ☐ No ☐

4. Does the patient have asthma or a history of wheezing in the last 12 months? Yes ☐ No ☐

5. Has the patient had Guillain Barre Syndrome? (A severe muscle illness also called GBS) Yes ☐ No ☐

6. During the past year, has the patient received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug? Yes ☐ No ☐

7. Does the patient take cortisone, prednisone, other steroids, or anticancer drugs, or has the person had radiation treatments? Yes ☐ No ☐

8. Has the patient received any vaccinations in the past 4 weeks? Yes ☐ No ☐
   Name of the vaccine:_____ Date received:_____

CAIR Disclosure

The California Immunization Registry (CAIR) CAIR is a confidential, secure computer system available to doctors and supported by the California Department of Public Health. Sharing patient immunization (shot) information is authorized by California State law. The flu vaccine received through this clinic will be entered into CAIR by the Alameda County Public Health Department. To view or download the CAIR Immunization Registry Notice (available in multiple languages), go to http://cairweb.org/cair-forms/

DO NOT WRITE BELOW THIS LINE

a. Is the patient pregnant? Yes ☐ No ☐ N/A ☐ b. Is the patient sick today? Yes ☐ No ☐

c. Nurse/Medical Staff ONLY - Reviewed By: _____ Date _____

Dose:	**Manufacturer**:	Lot #:	Injection Site :
☐ 0.5cc or ☐1.0cc	☐ Novartis ☐ Medimmune ☐ Other	Expiration Date: _____	☐ RD ☐ LD ☐ Intranasal