SAMPLE 2014 - 2015 *INFLUENZA NASAL SPRAY* VACCINE CONSENT AND SCREENING FORM

Section 1: Information about the student to receive vaccine (please print):

Name: (Last, First, MI)	Date of birth: ____ ____ ____ Month Day Year	Age	Sex: (Circle) Male Female
Street Address:			Student grade:
City:	State:	Zip:	Phone: ( )

Section 2: Consent

CONSENT FOR CHILD'S VACCINATION: I have read or had explained to me the 2014-2015 Vaccine Information Statement for the influenza vaccine and understand the risks and benefits.

I GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine. Children younger than 9 years of age may need 2 doses of vaccine. (If this consent is not signed, dated and returned, my child will not be vaccinated.)	**I DO NOT GIVE CONSENT** for my child named at the top of this form to get vaccinated with this vaccine.
_____ ____/____/____ Signature of Parent/Legal Guardian Date	_____ ____/____/____ Signature of Parent/Legal Guardian Date

Section 3: Permission to Share Information: Complete only if you consented to have your child receive flu vaccine. This information will be shared to ensure that your child is appropriately vaccinated. You may refuse to sign this authorization to share information. Refusal to sign will not affect your child's ability to obtain vaccine

I, _____, give permission to the individual and/or entity that administered the 2014 - 2015 influenza vaccine to my child _____ to share copies of the 2014 – 2015 flu vaccine consent form and vaccination record with my child's school and health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2014-2015 influenza consent form and vaccination record with each other.

(Print your name)

(Print child's full name)

My child's health care provider:

Name:_____

Address: _____

_____

My child's school:

Name:_____

City or town: _____

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
- This permission expires at the end of the 2014 – 2015 school year.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

_____

(School/institution/individuals handling withdrawals must insert name and address)

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.

_____ _____

Signature of Parent or Guardian Printed name of Parent or Guardian

Address:_____ Date signed:____/____/____

Permission to share is compliant with HIPAA and FERPA requirements.

Screening for Nasal Spray Influenza Vaccine

Complete this side only if you consented to have your child receive flu vaccine. Answering these questions will help us to know which type of flu vaccine your child should get and whether your child should get 0, 1 or 2 doses of flu vaccine.

Section 1: Information to determine if your child should receive 0, 1 or 2 doses of flu vaccine

If your child is 9 years old or older, go to Section 2 below.

If your child is 8 years old or younger, answer the other questions in this box.

1. Did your child receive 1 or more doses between July 1, 2013 and June 30, 2014? ☐ Yes ☐ No
2. If no, did your child receive 2 or more doses between July 1, 2010 and June 30, 2013? ☐ Yes ☐ No
3. Has your child received flu vaccine this flu season (since July 1, 2014)? ☐ **No If no, go to Section 2** ☐ **Yes**

   If yes, please tell us the number of doses and dates of vaccination. ☐ 1 dose ☐ 2 doses

   Dose 1: Date received: month ____ day ____ 2014 **Dose 2:** Date received: month ____ day ____ 2014

Section 2: Information to determine if your child should receive the 2014-2015 flu vaccine.

Please check YES or NO for each question. If you answer "YES" to one or more of the questions below, your child will not be able to get the nasal spray vaccine in school unless there is a note from your child's health care provider saying it is ok for your child to get flu vaccine. If you answer "NO" to these questions, your child will receive the vaccine. If you are not sure of the answers, check with your child's healthcare provider.

	NO	YES
1. Does your child have a problem eating eggs?		
2. Does you child have an allergy to gentamicin or gelatin?		
3. Has your child ever had a serious reaction to flu vaccine in the past?		
4. Has you child ever had Guillian-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
5. Has your child received any vaccine (not just flu) within the past 30 days? Vaccine: _____ *Date given:* month ____ day ____ year____		
6. Does your child have asthma?		
7. Does your child have diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
8. If your child is younger than 5 years old, has a healthcare provider told you that your child had wheezing or asthma within the last 12 months?		
9. Does your child take aspirin or aspirin-containing medicine every day?		
10. Is your child receiving antiviral medications?		
11. Does your child have a weak immune system (from HIV, cancer, or medicines such as steroids or those used to treat cancer)?		
12. Is your child pregnant?		
13. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?		

List all of your child's allergies:

_____

To help us determine if your child is eligible to receive vaccines from the Vaccines for Children Program, please check one of the boxes below. Your child will receive flu vaccine whether or not they are eligible.

- ☐ My child is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid)
- ☐ My child does not have health insurance
- ☐ My child is American Indian (Native American) or Alaska Native
- ☐ My child has health insurance and is not American Indian (Native American) or Alaska Native