City of Newton

Setti Warren
Mayor

Health & Human Services Department
Dori Zaleznik, MD, Commissioner
1000 Commonwealth Ave Newton, MA 02459
Telephone 617.796.1420 Fax 617.552.7063 TDD/TTY 617.796.7089

Student Flu Vaccine Consent and Screening Form 2013-14

Child's Last Name	Child's First Name	Date of Birth	Age	Gender: ☐ M ☐ F
Parent/Guardian Last Name	**Parent/Guardian First Name**		**Parent/Guardian Daytime Phone**	
School Name	**Teacher (K to 5th grade) OR Team (6th to 8th grade) Leave blank for 9th-12 graders**		**Grade**	

Select either flu shot or nasal spray.

- **Answer the screening questions only for that type of vaccine.**
- **Sign below those screening questions.**
- **A "YES" to any question (except #12) indicates your child cannot receive that type of vaccine. If you are not sure of the answers to these questions, contact your child's health care provider.**

Check **ONE** box below for the vaccine you want your child to receive.

☐ FLU SHOT

	Yes	No
1. Does your child have a problem eating eggs?		
2. Does your child have an allergy to gentamicin, neomycin, polymixin or gelatin?		
3. Has your child ever had a serious reaction to a flu vaccine in the past?		
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

I have read the 2013-2014 Vaccine Information Statement for the flu shot and understand the risks and benefits.
I GIVE CONSENT for my child to get vaccinated with this vaccine.

PARENT/GUARDIAN SIGNATURE:

_______________________________ DATE: _________

For all children 6 months through 8 years old:

Children in this age group should receive 2 doses of the 2013-2014 seasonal influenza vaccine at least 4 weeks apart unless they received:

- 2 or more doses of flu vaccine since July 1, 2010
  OR
- 2 or more doses of flu vaccine before July 2010 plus the 2009 H1N1 vaccine
  OR
- 1 or more doses of flu vaccine before July 2010 and 1 or more doses of flu vaccine after July 2010

Contact the child's primary health care provider to receive a second dose, or visit www.newtonma.gov/flu for additional clinics.

OR

☐ NASAL SPRAY

	Yes	No
1. Does your child have a problem eating eggs?		
2. Does your child have an allergy to gentamicin, neomycin, polymixin or gelatin?		
3. Has your child ever had a serious reaction to a flu vaccine in the past?		
4. Does your child have asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
5. If you 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?		
6. Does your child have a weak immune system (from HIV, cancer, or medicines such as steroids or those used to treat cancer)?		
7. Is your child taking antiviral medications?		
8. Does your child take aspirin or aspirin-containing medicine every day?		
9. Is your child pregnant?		
10. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
11. 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)?		
12. Has your child received any other vaccinations (not just flu) in the past 30 days? Vaccine: _________________ Date: ____/____/____		

I have read the 2013-2014 Vaccine Information Statement for the nasal spray and understand the risks and benefits.
I GIVE CONSENT for my child to get vaccinated with this vaccine.

PARENT/GUARDIAN SIGNATURE:

______________________________________ DATE: _________