City of Newton

Setti Warren
Mayor

Health & Human Services Department
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Public Health
Prevent. Promote. Protect.

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: _____

Student 2013-2014 Vaccine Administration Record/Insurance Information Form

The completion of this form is necessary for every vaccine recipient. If no insurance information is available, please fill out as much as possible using existing information.

Information about the person to receive vaccine (please print): *Required Fields

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

Insurance Information: *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)

If person getting vaccinated is not the subscriber, please complete the following: (Usually parent/guardian)

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * ____ ____ ____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:*	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

For children 18 years of age and younger:

- ☐ Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
- ☐ Does not have health insurance
- ☐ Is American Indian (Native American) or Alaska Native
- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

I give permission for my insurance company to be billed.

X _____ Date: _____

(Signature of patient, parent or legal guardian)

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For Clinic/Office Use Only: **Signature of Vaccine Administrator:** _____

Date of Service	Vax Type	Vax Mfgr	Lot No	Exp Date	Dose (mL)	State Supplied	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date on VIS	Date VIS given
	IIV3				0.5	Yes No	Yes No	IM	R Arm L Arm	7/26/13	9/13/13
	IIV4				0.5	Yes No	Yes No	IM	R Arm L Arm		
	LAIV4	MedImmune			0.2	Yes No	Yes	Intranasal	NA		

Provider Name: Newton Health & Human Services Department MDPH Provider PIN#: 11223
Provider Address: 1000 Commonwealth Ave. Newton, MA 02459