City of Newton
Setti Warren
Mayor

Health and Human Services Department
1000 Commonwealth Avenue, Newton, MA 02459-1544
Telephone 617.796.1420 Fax 617.552.7063 TDD/TTY 617.796.1089

Public Health
Prevent. Promote. Protect.

Student Flu Vaccine Consent and Screening Form 2017-2018

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	

Answer the flu shot screening questions and sign below

	Yes	No
1. Has your child ever had a serious reaction to a flu vaccine in the past?		
2. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

A "YES" to either question indicates your child cannot receive this vaccine at school. If you are not sure of the answers to these questions, contact your child's health care provider.

I have read the 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 2017-2018 seasonal influenza vaccine at least 4 weeks apart unless they received at least 2 doses of any seasonal influenza vaccine prior to July 1, 2017.

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

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Massachusetts law (M.G.L. c. 111, Section 24M) requires providers to report immunization information to a computerized immunization registry known as the **Massachusetts Immunization Information System (MIIS)**. The MIIS stores immunization records for you and your healthcare provider and can help prevent outbreaks of disease like measles and the flu. All information in the MIIS is kept secure and confidential. The MIIS allows information to be shared with health care providers, school nurses, local boards of health, and state agencies concerned with immunization. You have the right to object to the sharing of your immunization information across providers in the MIIS. For more information, please ask your healthcare provider, visit the MIIS website at www.mass.gov/dph/miis or contact the Massachusetts Immunization Program directly at 617-983-6800 or 888-658-2850.

Student 2017-2018 Flu Insurance Information Form & Vaccine Administration Record

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

Last Name*	First Name*	MI	Date of birth: *	Age*	Sex: (Circle)*
			____ ____ ____ Month Day Year		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:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: *	Sex: (Circle)*
	____ ____ ____ Month Day Year	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 Vaccine for Children (VFC) Program eligible:

- ☐ 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

Is not VFC-eligible:

- ☐ 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/Date VIS Given	Place sticker here	Injection Route	Injection Site (Circle)	Date On VIS
		IM	R Arm L Arm	8/7/15

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