



## Student Flu Vaccine Consent and Screening Form 2019-2020

Child's Last Name	Child's First Name	Date of Birth	Age
Parent/Guardian Last Name	Parent/Guardian First Name	Parent/Guardian Daytime Phone	
School Name	Teacher (preschool 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?		
3. Has your child ever had a serious allergic reaction after eating eggs?		
4. Does your child have an allergy to gentamicin, neomycin, polymixin, or gelatin?		

A "YES" to questions 1 and 2 indicates your child cannot receive this vaccine at school. A "YES" to questions 3 and 4 indicates your child *might* be able to receive this vaccine at school depending on the available formulation – please call 617-796-1420 for more information. 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 2019-2020 seasonal influenza vaccine at least 4 weeks apart unless they received at least 2 doses of any seasonal influenza vaccine prior to July 1, 2019.

**Contact the child's primary health care provider to receive a second dose, or visit [www.newtonma.gov/flu](http://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](http://www.mass.gov/dph/miis) or contact the Massachusetts Immunization Program directly at 617-983-6800 or 888-658-2850.

# 2019-2020 School 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: * ____/____/____ Month Day Year	Age*	Sex:*
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)
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**If person getting vaccinated is not the insurance subscriber/policy holder, please complete the following:**

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * ____/____/____ Month Day Year	Sex:*
Subscriber's Street Address: * <span style="color: red;">(If different from address above)</span>		
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 American Indian (Native American) or Alaska Native

Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)

Does not have health insurance

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	Vax Type	Vaccine Mfg	State Supplied	Preserv Free*	Lot No	Exp Date	Dose (mL)	Injection Route	Injection Site (Circle)	Date On VIS
Place sticker here								IM	R Arm   L Arm	8/15/19