Annual Influenza Vaccine Consent Form

REV. 9-9-2021

Section 1: Information about Child to Receive Vaccine (please print)

STUDENT'S NAME (Last)	(First)	(M.I.)	STUDENT'S DATE OF BIRTH month______ day____ year _________	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	STUDENT'S AGE	STUDENT'S GENDER M / F

ADDRESS			PARENT/GUARDIAN DAYTIME PHONE NUMBER:
CITY	STATE	ZIP	

STUDENT'S DOCTOR'S NAME (Last, First)	Address	City	Zip

SCHOOL NAME	HOMEROOM TEACHER'S NAME	GRADE

Section 2: Screening for Vaccine Eligibility

Was your child vaccinated with the seasonal influenza vaccine after July 1, 2021?
YES ☐ NO ☐

The following questions will help us to know if your child can get the seasonal influenza vaccine. If you answer "NO" to all four of the following questions, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, your child may be able to get the seasonal influenza vaccine, but we will contact you to discuss your options.
Please mark YES or NO for each question.

	YES	NO
1. Does your child have a serious allergy to eggs?	☐	☐
2. Does your child have any other serious allergies? Please list: ____	☐	☐
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:
I have read or had explained to me the 2021-2022 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

☐ **I GIVE CONSENT** to Clarinda Regional Health Center and its staff for my child named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then you child will not be vaccinated)

☐ **I DO NOT GIVE CONSENT** to Clarinda Regional Health Center and its staff for my child named at the top of this form to be vaccinated with this vaccine.

Signature of Parent/Legal Guardian: ____

Date: _______________________

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
Influenza	↑IM ↑Intranasal	/ /			