



# Student Flu Vaccine Consent & Release Form

**PLEASE PRINT**

**COMPLETE FORM FOR EACH CHILD**

STUDENT'S NAME (Last)		(First)	(M.I.)	STUDENT'S DATE OF BIRTH / /	
PARENT/GUARDIAN'S NAME (Last)		(First)	(M.I.)	Circle Gender M      F	Student's Age
ADDRESS			PHONE:		
CITY and STATE		ZIP	Daytime:	Home:	
SCHOOL NAME			SCHOOL TOWN		GRADE (circle one) K    1    2    3    4    5
HOMEROOM TEACHER'S NAME (Last, First) and HOMEROOM NUMBER				PHYSICIAN'S NAME:	

This vaccination program is being offered free to all elementary students; however for program purposes we need the following information. Please check the section that applies to your child: ( ) Medicaid Enrolled      ( ) Has no health insurance  
 ( ) American Indian/Alaskan Native      ( ) Has health insurance that does NOT pay for influenza vaccines  
 ( ) Has health insurance that DOES pay for influenza vaccines

The following questions will help us to determine if your child can get the influenza vaccine.

Please mark YES or NO for each question:

**YES    NO**

1. Does your child have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have any other serious allergies? Please list:	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had a serious reaction to flu (influenza) vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your child ever had Guillain-Barre <input type="checkbox"/> Syndrome (a type of temporary severe muscle weakness)?	<input type="checkbox"/>	<input type="checkbox"/>

### Consent for Child's Vaccination

I have read the Vaccine Information Statement for the *Inactivated Influenza Vaccine 2017-2018* or have had the information explained to me. I have had a chance to ask questions, which were answered to my satisfaction. I understand and acknowledge the benefits and risks of influenza vaccine and request that the vaccine be given to my child at school. I accept responsibility for seeking medical attention for any problems with this vaccination. I understand that if my child requires two doses of flu vaccine, it is my responsibility to get this second dose for my child. I acknowledge that I have read a Genesis Health System Notice of Privacy Practices. **I give consent for my child, for whom I am authorized to make this request, to Genesis and its' staff for my child to be vaccinated at school.**

Signature of Parent/Guardian \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Site	Route	Vaccine Manufacturer	Lot Number	Expiration Date
2017-2018 Inactivated Influenza	/ /	RD LD	IM 0.5 ml			06/30 /2018
Name & Title of Vaccine Administrator:						