

STUDENT Vaccination Consent Form— FLU SHOT

STUDENT'S NAME (Last)	(First)	(M. I.)	STUDENT'S DATE OF BIRTH / /
PARENT/GUARDIAN'S NAME (Last)	(First)	(M. I.)	STUDENT'S GENDER (Circle) Male Female
ADDRESS		PHONE DAYTIME: CELL: HOME:	
SCHOOL NAME		GRADE	HOMEROOM TEACHER'S NAME
STUDENT'S DOCTOR'S NAME		PRIMARY CLINIC	
STUDENT'S HEALTH INSURANCE: <input type="checkbox"/> (Circle one) - Medicaid / MA / Blue Plus / UCare / Prime West <input type="checkbox"/> Private Insurance <input type="checkbox"/> No Insurance <input type="checkbox"/> My insurance does not cover flu vaccine or it goes to my deductible			

The following questions will help us to determine if your child may receive the **FLU SHOT** (inactivated influenza vaccine). Please mark **YES** or **NO** for each question.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Has your child received a flu vaccine in the past? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has your child ever had a serious allergic reaction to eggs or to a component of any flu vaccine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has your child ever had a serious reaction to a previous dose of flu vaccine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has your child ever had Guillain-Barre Syndrome (a serious nervous system disorder)? | <input type="checkbox"/> | <input type="checkbox"/> |

CONSENT FOR CHILD'S VACCINATION: I have received and read the 2017 Vaccine Information Statement for the FLU SHOT (Inactivated Influenza Vaccine). I understand the risks and benefits and give consent for my child, named at the top of this form, to receive the FLU SHOT. I also consent to having information regarding my child's influenza vaccination shared with my child's doctor and my child's health insurance company.

Signature / Parent or Legal Guardian _____

Date: ____ / ____ / ____