ASD SEASONAL INFLUENZA (*Nasal FluMist)* VACCINE

CONSENT AND SCREENING 2012-13

School:	**Date:**

Dear Parent/Guardian:

1. Read the attached **Vaccine Information Statement** about seasonal influenza vaccine and keep for your records.
2. Complete the information regarding your child, answering the questions as indicated, and **sign the back of this form**, in the parent/guardian information section. **Use a separate form for EACH CHILD**.
3. Return *this* form to the School Nurse or Front Office even if your child will not receive the vaccine.

To provide the best health care, your child's immunization(s) will be entered into VAC TRAK, Alaska's immunization information system.

Student information

First Name	Last Name	Date of Birth mm/dd/yr	Teacher

MUST check one: ☐ Medicaid ☐ American Indian/Alaska Native ☐ Uninsured

☐ Underinsured (health insurance does not cover cost of vaccines) ☐ Not Applicable

PARENTS: PLEASE ANSWER ALL THE QUESTIONS BELOW:

	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?		
5. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nervous system, or blood?		
6. Is your child less than 5 years of age **AND** does he/she have recurrent wheezing?		
7. Has your child taken any antiviral medications (for example, Tamiflu) within the past 48 hours?		
8. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?		
9. Does your child have a weakened immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?		
10. Has your child been vaccinated with any vaccine within the past 30 days?		
11. Is your child pregnant?		
12. Does your child have close contact with a person who needs care in a protective environment (for example, someone who recently had a bone marrow transplant)?		

*** * Must complete other side * * * Must complete other side * * * Must complete other side**

Student Name: _____

PARENT/GUARDIAN INFORMATION

First Name	Last Name	Address	Phone

☐ ***Yes****, I give my permission for the child named above to be vaccinated with the FluMist Nasal Spray LAIV (live attenuated seasonal influenza vaccine) or other Flu Brand. I have read the Vaccine Information Statement and understand this consent will be valid for the number of doses recommended for my child's age and immunization history.*

☐ ***No,*** *I decline permission for my child listed above to be vaccinated with the seasonal influenza vaccine.*

☐ ***No,*** *my child has or will receive the vaccine from another provider.*

Parent/Guardian Signature _____ **Date** _____

Vaccinator use only: Form reviewed for child's name, contraindications, DOB, and consent to vaccinate

Is the child ill today? Yes No	**Date vaccine administered:** ***Vaccinator's Signature:***	**LAIV #1 Given:** **Amount 0.2 ml Route: Intranasal**	**VIS date**: 07/02/12 **Manufacturer:** **Lot#:** **Expiration Date:**
Is the child ill today? Yes No	**Date vaccine administered**: ***Vaccinator's Signature***	**LAIV #2 Given:** **Amount 0.2 ml Route: Intranasal**	**VIS date:** **Manufacturer:** **Lot#** **Expiration date**

Unable To Vaccinate This Child For The Following Reason: Date _____

☐ Refused to receive vaccine
☐ Consent form not properly completed
☐ Other
☐ Did not come to vaccination site
☐ Precaution/contraindication exists