

ASD SEASONAL INFLUENZA VACCINE CONSENT FORM FLU SHOT OR NASAL SPRAY 2014-15

Information collected on this form will be used to document authorization for receipt of 2014-15 influenza vaccine at your child's school. Information provided will be entered into **VAC-TRAK**, Alaska's immunization information system.

<i>Child's Name</i> :----- PLEASE PRINT CLEARLY -----			<i>Date of Birth</i> (mm-dd-yyyy) - -	
Last:	First:	M.I.		
Street Address:			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
City	State	Zip Code	Telephone Number ()	
Race (Check One) <input type="checkbox"/> Native American or Alaska Native <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American			Ethnicity (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
Mother's Maiden Name (Last, First)		Name of School:		Grade:
Name of Parent or Guardian Responsible for Child if under 18: (Last, First Middle)			Relationship to child:	
**This section MUST be completed: <input type="checkbox"/> Medicaid (Denali KidCare) <input type="checkbox"/> Insured, Vaccines <i>fully</i> Covered				
Patient Eligibility Status: <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> No Health Insurance				
Check all that apply <input type="checkbox"/> Insured, but Vaccines Not fully Covered				
Please answer the following questions so we can determine if your child can receive the 2014-2015 influenza vaccine and which vaccine is the best for your child. (Injectable vs. Intranasal Flumist)			YES	NO
Does your child have a nasal condition serious enough to make breathing difficult?				
Does your child have a serious allergy to eggs?				
Has your child ever had a serious reaction to a previous dose of flu vaccine?				
Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?				
Has your child received any vaccination in the last 4 weeks?				
Does your child have a chronic condition such as asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?				
Does your child have a weakened immune system (being treated for cancer, HIV, or taking steroid medication)?				
Is your child pregnant?				
Does your child have close contact with a person whose immune system is severely compromised and must be in a protected environment, or isolation? (i.e., someone who has recently had a bone marrow transplant?)				

**ASD SEASONAL INFLUENZA VACCINE CONSENT FORM
FLU SHOT OR NASAL SPRAY 2014-15**

STUDENT NAME: _____

Consent for Child's Vaccination:

Yes, I give my permission for the child named above to be vaccinated with the **FluMist Nasal Spray** LAIV (live attenuated seasonal influenza vaccine) and to share my child's immunization records including those provided to school(s) to be entered into **VAC-TRAK**, Alaska's immunization information system. I have read the Vaccine Information Statement for influenza vaccine and understand this consent will be valid for the number of doses recommended for my child's age and immunization history. *(If this consent form is not signed, then your child will not be vaccinated)*

Parent/Guardian Signature _____ Date signed _____

*Please fill out below **only if child cannot have Flumist due to medical condition***

Yes, I give my permission for the child named above to be vaccinated with the **Flu Injection** (inactivated vaccine) and to share my child's immunization records including those provided to school(s) to be entered into **VAC-TRAK**, Alaska's immunization information system. I have read the Vaccine Information Statement for influenza vaccine and understand this consent will be valid for the number of doses recommended for my child's age and immunization history. *(If this consent form is not signed, then your child will not be vaccinated)*

Parent/Guardian Signature _____ Date signed _____

Vaccination Record FOR ADMINISTRATIVE USE ONLY

Before vaccinating, review form for child's **name**, contraindications, DOB, and **consent** to vaccinate (Make sure **YES** consent box is marked and signed)

First Dose

Vaccine	Route	Date Dose Administered	Vaccinator's Signature	VIS date, Manufacturer Lot#, Expiration date
Influenza	<input type="checkbox"/> IM RD LD <input type="checkbox"/> IntraNasal			VIS Date: Manufacturer: Lot #: Expiration Date:

Second Dose

Vaccine	Route	Date Dose Administered	Vaccinator's Signature	VIS date, Manufacturer Lot#, Expiration date
Influenza	<input type="checkbox"/> IM RD LD <input type="checkbox"/> IntraNasal			VIS Date: Manufacturer: Lot #: Expiration Date: