School-Located Flu Vaccination Consent Form

Last Name *(Please print)*	First Name	MI	Age	Date of Birth ____/____/ _____	☐ Male ☐ Female
Address	City	State	Zip		
Phone Number	Email	Name of Doctor			
If student, print name of school he/she attends:		Grade			

HEALTH INSURANCE INFORMATION

Indicate insurance provider and subscriber number. Please include all letters/numbers.

☐ Blue Cross & Blue Shield ID#_____

☐ Tufts or Tufts/Carelink_____

☐ Neighborhood Health Plan of RI _____

☐ Neighborhood Health Plan of MA_____

☐ UnitedHealthcare ID#_____ Group #_____

☐ Aetna_____

☐ Medicare_____

☐ Other Insurance _____
(Insurance Name & ID Number)

☐ No Insurance

Flu Mist is not being offered this year based on CDC recommendations.

We apologize for any inconvenience this may cause.

SCREENING FOR FLU VACCINE ELIGIBILITY

If the answer to any question is "Yes", then we cannot vaccinate in school. Please contact your doctor to discuss options.

1.	Any serious allergy to eggs?	Yes	No
2.	Ever had a serious reaction to previous dose of flu vaccine that required medical attention?	Yes	No
3.	Ever had Guillain-Barre Syndrome (temporary severe muscle weakness) after receiving flu vaccine?	Yes	No
4.	Any allergy to Thimerosol or Latex?	Yes	No

I have answered "NO" to questions 1-4. I have viewed the Vaccine Information Statement(s) at www.immunize.org or viewed a hard copy obtained by calling the Rhode Island Department of Health (401-222-5960).

I understand the benefits and risks of the vaccine.

The injectable flu vaccine should be given to the person named above for whom I am authorized to make this request. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

Signature of Parent/Guardian/Patient_____ **Date**_____

Print Last Name_____ **Print First Name**_____

FOR ADMINISTRATIVE USE ONLY

VIS Date: 8/7/2015

Vaccine	Route	Manufacturer	Lot No.	
Influenza	*RA* *LA*			**Signature of Vaccine Administrator**_____ **Date vaccination and VIS given:** _____ / _____ / _____