



School \_\_\_\_\_ **FLU IMMUNIZATION CONSENT FORM** Grade \_\_\_\_\_  
Teacher \_\_\_\_\_

The Republic School District, in cooperation with Jordan Valley Community Health Center is offering **Seasonal flu vaccine** to any child who qualifies for the **Vaccines for Children (VFC) Program**, as supply allows. If you would like your child to receive the flu vaccine, please complete this form. All vaccines given at these clinics are provided free of charge.

**VACCINE OFFERED is Inactivated Influenza (FLU Shot)**

**1) QUALIFYING CHILDREN for VFC:** Check which applies for your child to receive **Seasonal flu vaccine** (at least one must apply).

\_\_\_\_\_ he/she has no insurance \_\_\_\_\_ he/she has insurance, but it does not cover vaccinations  
\_\_\_\_\_ he/she has Medicaid \_\_\_\_\_ he/she is an Alaskan native or Native American

In addition, for those students with **private insurance coverage** that fully covers vaccinations and therefore not qualifying for VFC, a limited amount of vaccine has been provided by Springfield Greene County Health Department, Cox Health, and Mercy Springfield and will be given free of charge as supply allows. Please **check** for your child to receive Seasonal Flu vaccine if available. \_\_\_\_\_ he/she **HAS** private insurance (not Medicaid) that pays fully for vaccinations

*We have attached Vaccine Information Sheets for each of the vaccines. If you have questions about the vaccines that cannot be answered by the attached Vaccine Information Sheets, please talk to your school nurse.*

**2) CHILD'S INFORMATION:**

Child's Name: \_\_\_\_\_ SS# \_\_\_\_\_ Gender: M F Race \_\_\_\_\_  
Child's Date of Birth: \_\_\_\_\_ Medicaid No: \_\_\_\_\_ Language: \_\_\_\_\_  
Child's Mother/Father/Guardian Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
Child's Street Address: \_\_\_\_\_ City \_\_\_\_\_ Zip: \_\_\_\_\_

**3) PLEASE CIRCLE 'YES' OR 'NO'**

- |   |     |    |
|---|-----|----|
| 1. Has your child received a vaccine within the past 30 days?   | Yes | No |
| If yes, please list name of vaccine(s): _____   |     |    |
| 2. Has your child received a flu vaccination before?  | Yes | No |
| 3. Is your child allergic to any part of the vaccine (eggs, egg proteins, gentamicin, gelatin, or arginine)?  | Yes | No |
| 4. Has the child ever had a life-threatening reaction to an influenza vaccine?  | Yes | No |
| 5. Is your child currently receiving aspirin or aspirin-containing therapy?   | Yes | No |
| 6. Does your child have asthma, recurrent wheezing, or active wheezing?   | Yes | No |
| 7. Has your child ever had Guillain-Barré syndrome?   | Yes | No |
| 8. Does your child have any diseases (for example, cancer, lupus, or HIV/AIDS) or take a medication (for example, steroids or chemotherapy) that lowers the body's resistance to infection?   | Yes | No |
| 9. Does your child have any of the following long-term health problems? (CHECK CIRCLE)  |     |    |
| ○ heart disease   ○ kidney disease   ○ metabolic diseases (for example, diabetes)   |     |    |
| ○ other _____   |     |    |
| 10. Is your child pregnant or nursing?  | Yes | No |
| 11. Please let us know if your child has close contact with anyone who has a weakened immune system (for example, an individual who has had a bone marrow transplant and is in a negative pressure hospital room). Please describe: |     |    |

Allergies/medical alert: \_\_\_\_\_

**4) READ AND SIGN BELOW:**

*Request for administration of inactivated Influenza (FLU Shot) for the above-named recipient:* I have been given the CDC Vaccine Information Statement. I have read this document and have no further questions at this time. I understand that my child will receive the inactivated Influenza (FLU shot) vaccine. I understand the risks and benefits of the inactivated intramuscular influenza vaccines. I request and voluntarily consent that the vaccine be given to the above-named recipient, of whom I am the parent or legal guardian, and I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the side effects and warnings of the vaccine.

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