NEW HAMPSHIRE SCHOOL (K- 12) VACCINATION CONSENT FORM 2016-2017 SEASONAL INFLUENZA

NH DIVISION OF Public Health Services
Improving health, preventing disease, reducing costs for all

SCHOOL NAME	TOWN	GRADE	TEACHER/HOMEROOM

SECTION 1: STUDENT INFORMATION

Student Name (Last)	(First)	(M.I.)	Student Date of Birth Month_____ Day_____ Year _____
Town	State	Zip	Student Age
Parent/Legal Guardian's Name (please print)			Parent/Guardian Daytime Phone Number

Please answer the following questions.

Is your child eligible for Medicaid? Yes___ No___

Is your child insured? Yes ___ No ___

What is the name of the child's insurance company?

_____

If you want your child's influenza vaccine information sent to their medical provider, please fill out the information below:

Medical Provider's Office Name _____

Medical Provider's Name_____

Street Address_____

Town and Zip Code_____

Phone Number_____

SECTION 2: SCREENING QUESTIONS

A: Your answers to the following section will help decide if your child can be vaccinated at school with the influenza vaccine. If you answer "yes" to any of these questions, please contact your medical provider to discuss other ways to receive the vaccine.

	YES	NO
1.Does your child have a serious allergy to eggs or any part of the influenza vaccine?		
2.Has your child ever had a serious reaction to a dose of the influenza vaccine in the past such as shortness of breath or has been told to not get influenza vaccine?		
3.Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) after receiving vaccine?		

SECTION 3: CONSENT FOR MY CHILD'S VACCINATION IN SCHOOL

I have read and understood the information contained on both sides of this form and I have reviewed the current Injectable Influenza Vaccine Information Statement at http://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf or have requested a copy by calling the NH Immunization Program at 603 271-4482. I understand that I can also request the Notice of Privacy Practice from 603-271-4482.

___**YES, I DO** want my child vaccinated with influenza vaccine at school:

Signature of Parent/Legal Guardian _____ Date: _____

___**NO, I DO NOT** want my child vaccinated with influenza vaccine at school:

Signature of Parent/Legal Guardian _____ Date: _____

SECTION 4: ADMINISTRATIVE USE ONLY. All sections must be completed by vaccinator.

BEFORE vaccinating, initial that you have completed the following:

____ Ask the student if they are feeling okay today. (If the student is not feeling well, tell the clinic leader or the school nurse)

____ Have you reviewed this ENTIRE form?

Publication date on Vaccine Information Statement (VIS): 8/7/15

Vaccine	Date Dose Given MM/DD/YYYY	Route	Manufacturer	Lot Number	Name and Title of Vaccine Administrator
		☐ IM -Deltoid L __ R__			

After the vaccination this completed form was reviewed by:_____