



**CONSENT FORM
SCHOOL FLU
CLINICS**

HHVN USE ONLY
 Clinic Location: CAPE ELIZABETH
 Cash/Check Check # \$10.00
Make checks payable to HHVN
 Unable to pay

p

PRINT CLEARLY.

Children Grades K-12

LAST NAME:		FIRST NAME:		MIDDLE:
ADDRESS:		CITY:	STATE:	ZIP:
BIRTH DATE:	AGE:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		PHONE #: ()

Insurance Information

(Circle your insurance)	ANTHEM	AETNA	MAINECARE
Enter Insurance ID #			

SCREENING TOOL

	<u>YES</u>	<u>NO</u>
• Has your child ever had a severe reaction to a previous influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
• Is your child allergic to eggs or chicken?	<input type="checkbox"/>	<input type="checkbox"/>
• Does your child have a past history of Guillain-Barre Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
• Is your child sick with a fever? (TEMPERATURE WILL BE TAKEN DAY OF CLINIC)	<input type="checkbox"/>	<input type="checkbox"/>
• STOP: If you answered yes to any of the above questions, your child cannot receive a flu vaccine at school. Contact your physician.		
• Does your child have asthma, lung disease, heart disease, diabetes, kidney problems, a blood disorder, immunodeficiency disease or are receiving aspirin or immunosuppressive therapies?	<input type="checkbox"/>	<input type="checkbox"/>
• Is your child pregnant or nursing? (Older students only)	<input type="checkbox"/>	<input type="checkbox"/>
• Is your child in close contact with anyone who has a severely weakened immune system? (These people require care in a protected environment.)	<input type="checkbox"/>	<input type="checkbox"/>
• Has your child received any other vaccinations in the past 4 weeks? Which ones?	<input type="checkbox"/>	<input type="checkbox"/>
• If you answered yes to the above 4 questions, your child will need a shot and should not get FluMist.		
• Has your child ever had the influenza Vaccine before? (Shot or mist)	<input type="checkbox"/>	<input type="checkbox"/>
• Children 8 and under receiving their first dose will need two doses 30 days apart.	<input type="checkbox"/>	<input type="checkbox"/>

I have been provided a copy of the **Influenza Vaccine Information Sheets** and had the opportunity to ask questions. I understand the benefits and risks of the influenza vaccine as described. I request that the vaccine be given to my child for whom I am authorized to sign. I acknowledge that no guarantees have been made concerning the results of the vaccine. I hold harmless, HomeHealth Visiting Nurses its employees, and the facility in which the vaccine was received. I request that payment of authorized benefits be made on my behalf directly to HomeHealth Visiting Nurses. I authorize transmission of vaccination record to my child's healthcare provider.

HEALTH CARE PROVIDER NAME _____ **FAX NUMBER** _____

X _____ **Date** _____
 Parent or guardian signature

STAFF USE ONLY BELOW THIS LINE

VACCINE: circle: FluMist Sanofi **EXPIRES:** _____ **NURSE'S SIGNATURE:** _____

DATE: ___ / ___ /09 **Lot #** A B C D **Dose:** 0.5ml **Deltoid injection site:** Left Right