NEW MEXICO DEPARTMENT OF HEALTH

ANNUAL SCHOOL INFLUENZA (FLU) IMMUNIZATION CONSENT FORM FLU SHOT 2016-17

YOUR COMMUNITY HEALTH CENTER
Las Clínicas del Norte

School name: _____ Grade: _____ Teacher: _____ Student ID#: _____

Student's legal last name: _____ First name: _____ Middle name: _____

Mailing address: _____ Zip: _____ Daytime phone: _____

Birth date: ____/____/____ Age: ____ Parent/legal guardian name: _____
month / day / year *first name and last name*

Race: ☐ American Indian/Native American/Alaskan Native ☐ Asian ☐ Other ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Gender: ☐ Male ☐ Female

INSURANCE INFORMATION—Fill in appropriate category—REQUIRED

Centennial Care/Medicaid: ☐ Blue Cross Blue Shield ☐ Molina Healthcare ☐ United Healthcare ☐ Presbyterian
*Centennial Care (Medicaid) / Policy/Member/ID #_____

Private/Commercial insurance: ☐ Blue Cross Blue Shield ☐ Presbyterian ☐ United Healthcare ☐ Other insurance: _____
* Member ID / Patient/Policy# / Group #: _____ Responsible Party: _____ Policy Holder's Date of Birth: _____

☐ **No health insurance**

MEDICAL SCREENING QUESTIONS—REQUIRED

Questions 1-2 help to determine if your child will need one or two doses of flu vaccine	NO	YES
1. Has your child received 2 or more doses of flu vaccine in their lifetime? (Not including H1N1-only vaccine)	☐	☐
2. Has your child received flu vaccine this flu season (since July 1, 2016)? *If "YES", how many doses and date(s) of vaccination: ☐ 1 Dose ☐ 2 Doses Date(s) received: _____	☐	☐
If you answer "YES" to either question below, your child cannot get vaccinated at school. Contact your child's doctor for options.	NO	YES
3. Does your child have a severe allergy (difficulty breathing, swollen face/lips, recurring vomiting) to eggs, or the following antibiotics: gentamicin, neomycin, or polymixin?	☐	☐
4. Has your child ever had a serious reaction to flu vaccine or developed Guillain-Barré Syndrome (a temporary severe muscle weakness)?	☐	☐
There are two types of flu vaccine available. If you answer "YES" to questions 5-12 below your child may not be able to get the nasal spray (live) vaccine, but may still be able to receive a flu shot, if available. The nurse will assess eligibility based on the answers to these questions.	NO	YES
5. Does your child have a severe allergy to latex or the food ingredients MSG, gelatin, arginine, or any other serious allergy? Please list:	☐	☐
6. Has your child received any vaccines within the past 30 days? Please list: _____ ; Dates given: _____	☐	☐
7. Has your child had an asthma attack, a wheezing episode, or taken asthma medicine within the past 12 months?	☐	☐
8. Does your child have: diabetes, diseases of the heart, liver, kidneys or lungs, seizures, blood disorder, anemia, neuromuscular disease, or cerebral palsy?	☐	☐
9. Is your child on long-term aspirin-containing therapy, for example, does your child take aspirin every day?	☐	☐
10. Does your child have a weakened immune system (for example, from HIV, cancer, or medicines such as steroids or those used to treat cancer)?	☐	☐
11. Does your child have close or direct contact with someone who is in a protected environment for an extremely weakened immune system (for example, bone marrow transplant unit)?	☐	☐
12. Is your child pregnant?	☐	☐

CONSENT FOR CHILD'S VACCINATION IN SCHOOL

I have read or had explained to me the **2016-17 Intranasal Influenza Vaccine Information Statement (VIS)** and the **2016-17 Injectable Influenza Vaccine Information Statement** and understand the benefits and risks of influenza vaccine and consent that the influenza vaccine be given to the person above for whom I am authorized to make this request. If the person above for whom I am authorized to make this request is less than 9 years old and it is determined that a 2nd dose is needed, I also consent for a 2nd dose of vaccine to be given if offered through the school. **I will contact the school nurse to withdraw this consent if this child is immunized before the date of the school clinic or if I choose to do so.** Unless I sign a statement signifying otherwise, I allow immunization information to be entered into the New Mexico Statewide Immunization Information System (NMSIIS) and be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status. The DOH Privacy Policies are available at http://nmhealth.org/help/privacy/ and will be given to all patients when they receive an immunization.

Signature of parent/legal guardian: _____ **Date:** _____
Print name of parent/legal guardian *(print legibly in all capitals):* _____

For clinic use (this section must be completed by the medical provider) ***VIS date: 2016-2017***

Dose #1 **VFC PIN#** _____ **Date data entry completed** _____ **Date vaccinated** _____

VACCINE: ☐ FluMist® MedImmune ☐ IIV Fluarix GSK **Lot #** _____ **Exp. date** _____
Site of administration: ☐ Intranasal ☐ R Deltoid ☐ L Deltoid Other_____
Name and Title of Vaccine Administrator_____
Precetor Name & Credentials_____

Dose #2 **VFC PIN#** _____ **Date data entry completed** _____ **Date vaccinated** _____

VACCINE: ☐ FluMist® Medimmune ☐ IIV Fluarix GSK **Lot #** _____ **Exp. date** _____
Site of administration: ☐ Intranasal ☐ R Deltoid ☐ L Deltoid Other_____
Name and Title of Vaccine Administrator_____ **Preceptor Name & Credentials**_____

****Required: Date VIS given to patient (Stamp or print)**