

Section 1: Information about Child to Receive Vaccine (please print)

CHILD'S NAME (Last)	(First)	(M.I.)	CHILD'S DATE OF BIRTH month _____ day _____ year _____
ADDRESS	CHILD'S AGE	CHILD'S GENDER M / F	
CITY/STATE/ZIP			
PARENT/LEGAL GUARDIAN'S NAME (Last)	(FIRST)	PARENT/GUARDIAN DAYTIME PHONE NUMBER:	
CHILD'S DOCTOR'S NAME (Last, First)	Address	City	Zip
SCHOOL NAME	HOMEROOM TEACHER'S NAME	GRADE	

Section 2: Vaccination Fee –(Check only ONE box) MY CHILD -

- Is enrolled in Medicaid. Child's Medicaid number: _____
- Does not have health insurance = Vaccination Fee \$10
- is of Alaskan or Native American decent = Vaccination Fee \$10
- HAS health insurance covering the FULL flu vaccination cost = Vaccination fee \$20

Section 3: Screening for Vaccine Eligibility: MUST answer YES or NO for each question.

The following four questions will help us to know if your child can get the influenza vaccine. If you answer "NO" to all of them, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following questions, your child may be able to get the seasonal influenza vaccine, but we will contact you to discuss your options.	YES	NO
1. Does your child have an allergy to eggs?	YES	NO
2. Does your child have any other serious allergies? Please list: _____	YES	NO
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	YES	NO
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO
There are two kinds of seasonal influenza vaccine, intranasal and injection. Your answers to the following questions will help us know which of the two kinds of vaccine your child can get.		
1. Has your child been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month _____ day _____ year _____	YES	NO
2. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	YES	NO
3. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	YES	NO
4. Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	YES	NO
5. Is your child pregnant?	YES	NO
6. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	YES	NO

Section 4: CONSENT FOR CHILD'S VACCINATION:

I have read or had explained to me the 2013-2014 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits. **I GIVE CONSENT** to the MONROE COUNTY HEALTH DEPARTMENT and its staff for the person named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then child will not be vaccinated)

Signature of Parent/Legal Guardian _____ Date: month _____ day _____ year _____

Section 5: Vaccination Record -FOR ADMINISTRATIVE USE ONLY

Influenza Vaccine	Route	Date Dose Administered	Site	Lot Number	Name and Title of Vaccine Administrator
FLU	Intranasal	/ /	Deltoid R L		