2018- 2019 Injectable or Flumist Influenza Vaccine Consent and Screening Form for Children

18 years old and under: Section 1: Information about the student to receive vaccine (please print):

Student's Name: (Last, First, MI)	Date of birth: ____ ____ ____ Month Day Year	Age	Sex: (Circle) Male Female
Street Address:	Student School & Grade/School		
City:	State:	Zip:	Phone: ( )

Insurance Information: *Include the whole member ID number and any letters that are part of that number*
MUST PROVIDE A COPY OF ALL YOUR CHILD'S INSURANCE CARDS (please staple to this form)

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
Name of Secondary Insurance Company	Member ID Number:*	Group ID Number: (if available)

Please complete the following:

Subscriber's Name: (Last, First, MI)*	Subscriber's Date of Birth: * ____ ____ ____ Month Day Year	Sex: (Circle)* Male Female
Subscriber's Street Address:* (If different from address above)		
City:*	State:*	Zip: *	Phone:* ( )
Patient Relationship to Subscriber: (Circle)* Spouse Child Other		

Massachusetts law (M.G.L. c. 111, Section 24M) ***requires*** providers to report immunization information to a computerized immunization registry known as the Massachusetts Immunization Information System (MIIS). The MIIS stores immunization records for you and your healthcare provider. All information in the MIIS is kept secure and confidential. The MIIS allows information to be shared with health care providers, school nurses, local boards of health, and state agencies concerned with immunization. You have the right to object to the sharing of your immunization information across providers in the MIIS. For more information, please ask the nurse giving you the shot or contact the MA Immunization Program directly at 617-983-6800 or 888-658-2850.

I have read the information (VIS for injectable influenza vaccine and Flumist) provided about the vaccine I am receiving today. I understand the risks and benefits of the vaccine and authorize the Westford BOH to both administer the vaccine as well as to bill my insurance company. I have been informed about the Massachusetts Immunization System (MIIS). I have received the VIS and the *MIIS Fact Sheet for Parents and Patients*. Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to: Westford Health Department, 55 Main St, Westford, MA 01886

I DO _____ DO NOT _____ Give permission for my child's flu vaccine information to be entered into the MIIS

_____ _____ _____
Parent/Guardian Signature **Printed Parent/Guardian Name** **Date**

I GIVE CONSENT for my child named at the top of this form to get vaccinated with Influenza vaccine and for my insurance company to be billed.
(If this consent is not signed, dated and returned, my child will not be vaccinated.)

_____ Date: _____
(Signature of parent or legal guardian)

Please complete page 2 ►►►►

DEADLINE TO PRE-REGISTER in schools: Wednesday, October 24, 2018
in addition: form used at public flu clinics as well as, for schools 2018-2019

For children 18 years of age and younger:

- ☐ Is enrolled in Medicaid (includes MassHealth and HMOs etc. if enrolled through Medicaid)
- ☐ Does not have health insurance
- ☐ Is American Indian (Native American) or Alaska Native
- ☐ Has health insurance and is not American Indian (Native American) or Alaska Native

Screening Questions: All 12 questions MUST be answered or your child will NOT be vaccinated!

1. Has your child ever received a flu shot or Flumist ? YES NO If YES which one _____
2. .Is your child allergic to eggs or egg protein? YES NO If YES cannot receive either vaccine
3. Is your child allergic to gentamicin, gelatin, or arginine? YES NO If YES cannot receive Flumist
4. .Has your child ever had Guillain-Barre syndrome? YES NO If YES cannot receive either vaccine
5. Has your child ever had a life threatening reaction to flu vaccine? YES NO
6. Is there a chance that your child is pregnant? YES NO If YES cannot receive Flumist
7. Is your child receiving long term aspirin or aspirin-containing therapy? YES NO If YES cannot receive Flumist
8. Does your child have diabetes, kidney, heart, or lung disease? YES NO If YES cannot receive Flumist
9. Has your child received any other vaccines within the 30 days of the vaccine date for your child's school? (ie.MMR, chicken pox, etc.)? YES NO If "YES" please list vaccine type:_____ and date _____
10. Does your child have a weakened immune system? (ie. from cancer drugs, high dose steroids, HIV, etc.) YES NO If YES cannot receive Flumist
11. Will your child be around a person who has a severely weakened immune system? (ie.: recent bone marrow transplant, or is in protective isolation) YES NO If YES cannot receive Flumist
12. Has your child ever had recurrent wheezing, a history of asthma or a condition requiring the use of an inhaler at any time in her or her life? YES NO If YES cannot receive Flumist

List all of your child's allergies:

_____

PLEASE Indicate which vaccine you wish your child to receive by circling your selection:

(YOU MUST CIRCLE A CHOICE OF VACCINE OR FLUMIST *SEE RESTRICTIONS ON FLUMIST)

I have a limited supply of Flumist so it will be given out on a first come first serve basis based on when you signed and submitted the consent form

CIRCLE ONE CHOICE: I would like my child to receive:

FLULAVAL (Injection) Westford Academy, Stony Brook and Blanchard ONLY

FLUMIST (Intranasal)

_____ _____

Signature of parent or guardian **Date**

If you sign your child up for this program and he/she receives the vaccine at another venue (ie. doctor's office) after you've registered but before the clinic dates, please contact the health dept secretary at 978-692-5509 to have your child's name removed from our list.

BELOW FOR CLINIC USE ONLY:

Date vax given:	Vax Type	Vax Manufacturer	Exp. Date/ Lot No	Dose	State Supplied	Preserv Free	Injection Route	Injection Site (Circle)	Date On VIS	Date VIS given
	QIV FluLaval	GSK		0.5mL	Yes	Yes	IM	R Arm L Arm	8/7/15	
	LAIV Flumist	Astra Zeneca		0.2mL	Yes	Yes	Intranasal	NA	8/7/15	

Vaccine Administrators Signature: _____

Clinic Site Name: Westford Health Dept
Clinic Address: 55 Main St, Westford, MA 01886 MDPH Provider PIN#: 11994

Gail Johnson, BSN, RN Public Health Nurse: Date: