Influenza Vaccination Screening and Consent Form

Please check √ Yes or No to the following questions. Please answer all questions.

General Medical Questions	Yes	No
1. Does your child have a fever or feel sick today?		
2. Has your child ever had a serious reaction to a flu vaccine or a component in the vaccine (MSG, arginine, gentamicin, and gelatin)?		
3. Has your child ever had a severe allergic reaction to eggs that required medical attention?		
4. Has your child ever had Guillain-Barré Syndrome (GBS)?		
Section A: Inactivated Influenza Vaccine (TIV)	**Yes**	**No**
1. Does your child have a severe allergy to thimerosal, a preservative used in some vaccines?		
2. Does your child have an allergy to latex?		
Section B: Live Attenuated Influenza Vaccine (LAIV)	**Yes**	**No**
1. Is your adolescent child known to be pregnant?		
2. Does your child have any of the following long-term medical conditions? • Asthma • Heart disease • Lung disease • Kidney disease • Metabolic disease (such as diabetes) • Liver disease (hepatitis, cirrhosis) • Blood disorder (leukemia, lymphoma, sickle cell disease)		
3. Has your child (under 5 years of age) been diagnosed with wheezing in the last 12 months? (Leave blank if your child is 5 years of age or older.)		
4. Does your child have a weakened immune system due to HIV/AIDS or other diseases affecting the immune system, long-term steroid therapy, or cancer treatment with drugs or x-rays?		
5. Does your child have a muscle or nerve disorder that can lead to breathing or swallowing problems such as a seizure disorder or cerebral palsy?		
6. Is your child currently receiving long term aspirin therapy or a medicine containing aspirin?		
7. Has your child received MMR (measles-mumps-rubella), Varicella (chickenpox) vaccine or a live influenza vaccine within the last 4 weeks?		
8. Does your child live with or have close contact with a person who has a severely weakened immune system who must be in a protective environment such as a hospital room with reverse air flow (for example a bone marrow transplant unit)?		
If your child is under 9 years of age, he/she may need two doses of flu vaccine. Please complete this section <u>only</u> if your child is under 9 years of age so we may determine whether two doses are needed.		
	Yes	**No**
1. Did your child receive at least one dose of seasonal flu vaccine last year?		
2. What is your child's date of birth?	__ __/__ __/ __ __ *(example 05/08/80)*	

CONSENT FOR CHILD'S VACCINATION

I have read the Influenza Vaccine Information Statement (VIS) for the Influenza Vaccine and understand the risks and benefits of the vaccine. I have had a chance to ask questions. I give permission for my child or a child under my custody to receive the flu vaccine.

Child's Name (Print) _____ **School Name** _____ **Date** _____

Parent/Guardian Name (Print) _____ **Parent/Guardian Signature** _____