HEALTHY KIDS CLINIC
A Part of Cumberland Family Medical Center, Inc.
Healthy Children. Healthy Schools.

Toll Free: 844-435-0900

FLU SHOT CONSENT FORM

Only Complete If You Wish for Your Student to Receive an Influenza Vaccine
A District Wide "All Call" Will Be Sent Out to Parents Notifying You of The School Districts Flu Clinic Dates

Dear Parent/Guardian,

The Healthy Kids Clinic will have influenza (flu) vaccinations available to students during the flu season months. Please sign below if you give permission for your child to receive the flu vaccine on the day our provider and nurse visit your child's school. Please note, the Center for Disease Control (CDC) recommends that children six months and older receive the Influenza vaccine annually.

Student Name: _____ Male/Female:_____ Allergies:_____

School Name: _____ Homeroom: _____ Birthdate: _____

Address:_____ Zip Code:_____

Phone Number:_____ Social Security Number:_____

Insurance Company:_____ Policy Number:_____ Group Number:_____

Policy Holder Name: _____DOB: _____ Relationship To Patient:_____

Address Of Policy Holder If Different Than Patient:_____

Language: _____ Race: _____Hispanic/Non-Hispanic: _____

The FLU INJECTION is given in the muscle. Some conditions are precautions or contraindications to receive this vaccine please answer the following questions regarding your child:

- Does your child have an allergy to eggs? ❑Yes ❑No
  If yes, what was the reaction?_____
- Does your child have an allergy to Neomycin, Polymyxin, Kanamycin, or Gentamicin? ❑Yes ❑No
- Does your child have a history of a severe allergic reaction to a flu vaccine? ❑Yes ❑No
- Does your child have a history of Guillain-Barre' syndrome within 6 weeks following a previous flu vaccine? ❑Yes ❑No

***If you answer yes to any of the above questions and feel as though your child should receive the flu vaccine, we encourage you to schedule an appointment with your primary care provider to determine if the flu vaccine is appropriate for your child.**

By signing this consent, I as the guardian of the above-named student give permission for this student to receive the influenza vaccine given by the Healthy Kids Clinic in the student's school. I understand that that if I take my student to receive the influenza vaccine at another clinic, I should let my students school nurse know immediately.

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____**Date**:_____

If Your Child Is Eight Years or Younger, Please See Below

The CDC recommends that all children between the ages of six months and eight years who have not received 2 doses of trivalent or quadrivalent flu vaccine prior to 7/1/2021 need to have two-doses of the flu vaccine for maximum protection. These doses are separated by 4 weeks. If your child is six months through eight years of age and meets the above criteria, we can offer both doses through the Healthy Kids Clinic. By initialing below, you as the parent or guardian give consent for your child to receive the two-part influenza vaccine series.

Please Initial by Vaccine: _____**Two-Part Flu INJECTION**

Office Use Only:

Lot #:_____ Exp. Date_____ Manufacture_____ Date Given_____

VS: (T)_____ (P)_____ (O2 sat)_____ Nurses Name:_____ Inj. Site:_____

https://www.cdc.gov/mmwr/volumes/69/rr/rr6908a1.htm?s_cid=rr6908a1_w#recommendationsfortheuseofinfluenzavaccines,2020%E2%80%9321

https://www.chop.edu/centers-programs/vaccine-education-center/vaccine-ingredients/antibiotics#:~:text=Influenza,per%20dose)%3A%20%3C%200.011mg

https://www.cdc.gov/flu/professionals/acip/summary/summary-recommendations.htm