



### 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 GUARDIANS NOTIFYING OF FLU 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 permit 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: \_\_\_\_\_ Sex Assigned At Birth : \_\_\_\_\_ Allergies: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
School Name: \_\_\_\_\_ Homeroom: \_\_\_\_\_ Language: \_\_\_\_\_ Race: \_\_\_\_\_  
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: \_\_\_\_\_ Hispanic/Non-His: \_\_\_\_\_

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

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 all children between 6 months and 8 years who have not previously received 2 doses of influenza vaccine greater than 4 weeks apart before July 1, of this year, receive two doses of the flu vaccine separated by at least 4 weeks for maximum protection. If your child is 6 months through 8 years of age and meets the above criteria, we can offer both doses through 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 \_\_\_\_\_ Manufacturer \_\_\_\_\_ Date & Time  
Given \_\_\_\_\_ VS: (T) \_\_\_\_\_ (P) \_\_\_\_\_ (O2 sat) \_\_\_\_\_ Nurses Name: \_\_\_\_\_ Inj. Site: \_\_\_\_\_