



Anchorage School District
Healthcare Services
Flu Vaccine Consent for Students



Student Information

Last:	First:	DOB:
Address:		
City:	State:	Zip:

Please select the best option that applies to the student

- ☐ Alaska Native or American Indian (VFC Eligible)
☐ Denali KidCare (Medicaid) (VFC Eligible)
☐ Underinsured (health insurance does not cover vaccines) (VFC Eligible)
☐ No health insurance (VFC Eligible)
☐ None of the above (State AVAP)

Health Screen

The following questions will help us determine if there is any reason we should not give you or your child injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Questions	Yes	No
Is the person to be vaccinated sick today?	☐	☐
Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	☐	☐
Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?	☐	☐
Has the person to be vaccinated ever had Guillain Barré Syndrome ?	☐	☐

Parent/Guardian Information and Consent

I have reviewed the current Vaccine Information Sheet (VIS) and understand the risks, benefits, and potential side effects (such as soreness, mild flu-like symptoms, or rare allergic reactions) of the flu vaccine. I consent to the Anchorage School District administering the recommended doses of the flu vaccine to me (or my child). I authorize the nurse to report this administration to the State of Alaska's VacTrAK system. I release the Anchorage School District and its personnel from any claims or liability resulting from this vaccination.

Name: _____
Signature: _____

Phone: _____
Date: _____

THANKS FOR HELPING KEEP OUR COMMUNITY HEALTHY!

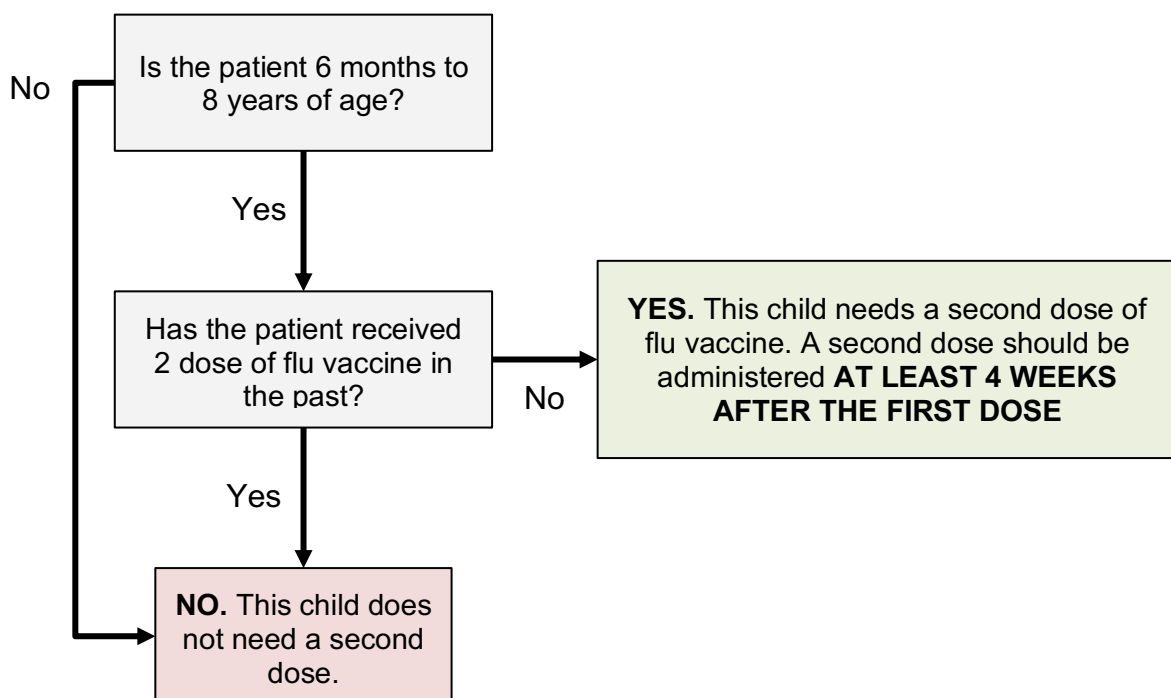


Anchorage School District
Healthcare Services
Flu Vaccine Consent for Students

For Nurse Use Only to Document Administration

Vaccine	Date	Route	Vaccine Info	Signature
6mos – 64 y.o. Influenza, split virus, trivalent, PF		☐ IM – Deltoid ☐ L ☐ R ☐ IM – Thigh	Lot#: Exp. Date: VIS Date:	

SHOULD THIS PATIENT RECEIVE A SECOND DOSE?



For children 8 years of age who need two doses of vaccine, both doses should be administered even if the child turns 9 years of age between receipt of dose 1 and dose 2.

For Nurse Use Only to Document Second Dose Administration, if indicated

Vaccine	Date	Route	Vaccine Info	Signature
6mos – 64 y.o. Influenza, split virus, trivalent, PF		☐ IM – Deltoid ☐ L ☐ R ☐ IM – Thigh	Lot#: Exp. Date: VIS Date:	