Clinic Location: _____

Time Vaccinated: _____

SEASONAL INFLUENZA VACCINE
RECORD AND CONSENT FORM

SECTION 1: STUDENT INFORMATION

School Name	School Town	Grade	Teacher/Homeroom

Student Name (Last)	(First)	(M.I.)	Age

Town	State	Zip	Date of Birth (mm/dd/yyyy)

Parent/Legal Guardian's Name	Parent/Guardian Daytime Phone Number

Does your child currently have Medicaid, Well Sense, NH Healthy Families or AmeriHealth Caritas? Yes ☐ No ☐	**We will provide you with a copy of your child's immunization information. We recommend that you share this information with your child's physician.**

SECTION 2: SCREENING QUESTIONS

Please answer the following questions, to help keep your child safe. If you answer "yes" to any of the questions, please contact your child's medical provider to discuss other ways to receive the vaccine.	**YES**	**NO**
1. Does your child have an allergy to eggs or any component of the influenza vaccine?	☐	☐
2. Has your child ever had a serious reaction after a dose of the influenza vaccine or been told to not get the influenza vaccine by a healthcare provider?	☐	☐
3. Has your child ever had Guillain-Barré Syndrome (an autoimmune neurological condition that results in sudden muscle weakness)?	☐	☐

SECTION 3: CONSENT FOR MY CHILD'S VACCINATION IN SCHOOL

I have reviewed the Influenza Vaccine Information Statement at: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf. I have had any questions satisfactorily answered. I understand the risks and benefits of receiving the influenza vaccine.
By signing below, I give consent for the minor, named above, to be vaccinated with an influenza vaccine at the school clinic.

YES, I do want my child, named above, to receive the influenza vaccine at school.
Signature of Parent/Legal Guardian:_____ Date: _____

SECTION 4: ADMINISTRATIVE (INTERNAL) USE ONLY. Vaccine administrator must complete all sections.

BEFORE vaccinating, check that you have completed the following (check to confirm done):

☐ I have asked the student if they are feeling sick or unwell today
☐ I have reviewed this entire form including the screening questions

If sick or "yes" to any of the screening questions, do NOT give the vaccine.

☐ Child Not Vaccinated
Reason:_____

Provider Name & Address:	**Name and Title of Vaccine Administrator:**
	Signature of Vaccine Administrator:

Vaccine	**Manufacturer**	**Lot Number**	**Route** ☐ IM L Deltoid ☐ IM R Deltoid ☐ Other	**VIS Publication Date**	**Administration Date**

After vaccination this form was reviewed by: _____