Type: Mist or IM
Doses: 1 or 2

Cincinnati Health Department
School and Adolescent Health
Consent Form for 2015-2016 Seasonal Influenza Vaccine

COMPLETE THIS FORM IF YOU WANT YOUR CHILD TO GET THE FLU VACCINE

A. SCHOOL NAME: _____ PowerSchool ID_____

STUDENT NAME (Last)	**(First)**			**(M.I.)**	**GRADE/HR**
DATE OF BIRTH	**AGE**	**GENDER M / F**	**RACE**	**PHONE NUMBER**	
STREET ADDRESS	**CITY**		**STATE**	**ZIP**	

INSURANCE STATUS:
□ **Medicaid** □ **Caresource** □ **United Healthcare Community Plan** □ **Molina** □ **Paramount** □ **Buckeye**
□ **No Insurance** □ **Private Insurance _____** □ **Other_____**
Medical Card Billing Number# _____ **Child's SS#_____**
*No student will be denied the flu vaccine due to inability to pay or lack of insurance

B. In order to determine if your child needs a booster dose, please answer this question**:**

1. Did your child receive **2 doses** of seasonal flu vaccine since July 2010? □ Yes □ No □ Unsure

C. Please answer all of the following questions:

	YES	**NO**
1. Is the student sick today with fever or respiratory illness?	□	□
2. Does the student have a serious allergy to eggs, thimerosal or another component of the flu vaccine?	□	□
3. Has the student ever had a serious reaction to a previous dose of flu vaccine?	□	□
4. Has the student ever had Guillain-Barré Syndrome (a temporary severe muscle weakness) within 6 weeks after receiving flu vaccine?	□	□

D. Please answer all of the following questions:

	YES	**NO**
1. Does the student have a long term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia or another blood disorder?	□	□
2. If the student is between the ages of 2 and 4 years old, in the past 12 months has a health care provider told you that he or she had wheezing or asthma?	□	□
3. Does this student have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long term treatment with drugs such as high dose steroids, or cancer treatment with radiation or drugs?	□	□
4. Does the person have close contact with someone who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	□	□
5. Is the person on long-term aspirin or aspirin-containing therapy (for example, does the person take aspirin every day)?	□	□
6. Is the student receiving anti-viral medications?	□	□
7. Is the person pregnant or could become pregnant in the next month?	□	□
8. Has the person received any of the following vaccinations within the past 30 days? MMR, Varicella, or FluMist? If yes, give type and date. Recent Vaccinations: _____Date received: _____	□	□

E. Consent

CONSENT FOR VACCINATION:
I understand I will receive the **2015 Flu Vaccine Information Statement** and **Cincinnati Health Department Notice of Privacy Practices prior to my child receiving the vaccine.**

I GIVE CONSENT for the student named at the top of this form to receive the Flu vaccine.

Signature of Person/Parent/Legal Guardian _____ Date: month _____ day _____ year_____
Print Name of Parent Legal/Guardian_____
Parent Cell Phone Number: _____

F: Vaccination Record (FOR ADMINISTRATIVE USE ONLY): ICD-9 V068 Provider: 2402

Vaccine	**Date Dose Administered**	**Route**	**Lot Number**	**Name and Title of Vaccine Administrator**
2015 Seasonal Flu	/ /2015	□Intranasal		
		□ IM		
Booster Dose	/ /2015	□Intranasal		
		□ IM		