Sleepy Eye Medical Center

Injectable Influenza Vaccination Screening and Consent Form

Parents/Guardians: Please read the following carefully before signing the consent.

For your child to be eligible to receive influenza vaccine at the school clinic, **you must read, answer all questions, and sign this consent form.** Please read the vaccine information statement we have provided to you. If this is the first time that a child under the age of 9 receives the influenza vaccine, or if they have not received two or more doses of influenza vaccine previously, they will need a second dose approximately 4 to 6 weeks after the first dose. The second dose can be scheduled by calling the Sleepy Eye Medical Center at (507) 794-3691.

Child's name- Last: First: M.I.:		Parent/Legal Guardian's Name: Last: First: M.I.
Child's age: _____ Date of Birth: Month: Date: Year:	Gender:(Circle) M or F	Address:
Child's Doctors Name/Clinic:		City: State: Zip:
Name of School:		Parents phone number: ( ) _____- _____
Child's Teacher:		Child's Grade:
INSURANCE INFORMATION OR ATTACH COPY OF INSURANCE CARD OF CHILD		
Insurance Company Name:		Patient's Policy ID Number:
Insurance Claims Address:		Group Number:
Insurance Phone Number:		Additional information:
Subscribers/Policy Holder's Name: _____ and Date of Birth ___/____/_____		

Please circle YES, NO or Non-Applicable for the following questions and answer **ALL** questions:

1. Is your child allergic to eggs?	Yes No
2. Has your child ever received the influenza (flu) vaccine before?	Yes No
3. Has your child ever had a serious allergic reaction to the influenza (flu) vaccine or to any other type of vaccine? If yes, please explain_____	Yes No
4. If your child is less than 9 years old **AND** he/she received the flu vaccine <u>for the first time last year,</u> did he/she get 2 doses?	Non-Applicable Yes No
5. Has your child received a MMR and/or Varicella (Chickenpox) vaccine in the past 4 weeks?	Yes No
6. Does your child have any chronic medical conditions? If yes, please write the medical condition(s): _____ If your child has asthma, how often does he/she use an inhaler? _____ AND How many times per year does your child see a doctor for asthma? _____	Yes No
7. Does your child take Aspirin every day?	Yes No

I have read or had explained to me the vaccine information statements for **the Injectable Influenza Vaccine** (Vaccine information statement). I give permission for my child whose name is listed above to receive the influenza (flu) vaccine.

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

FOR CLINIC USE ONLY								
Date:	Dose:	Vaccine/MFG:		Lot#	Exp. Date	Screening MD/RN/LVN	IZ Given By:	Site/Route
	#1							N/IM
	#2							N/IM