



2016-2017 School-Located Flu Vaccination Consent Form

Last Name <i>(Please print)</i>		First Name	MI	Age	Date of Birth ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address			City		State	Zip
Phone Number		Email		Name of Doctor		
If student, print name of school he/she attends:					Grade	

HEALTH INSURANCE INFORMATION
Indicate insurance provider and subscriber number. Please include all letters/numbers.

<input type="checkbox"/> Blue Cross & Blue Shield ID# _____	<input type="checkbox"/> Tufts or Tufts/Carelink _____
<input type="checkbox"/> Neighborhood Health Plan of RI _____	<input type="checkbox"/> Neighborhood Health Plan of MA _____
<input type="checkbox"/> UnitedHealthcare ID# _____ Group # _____	<input type="checkbox"/> Aetna _____
<input type="checkbox"/> Medicare _____	
<input type="checkbox"/> Other Insurance _____ <i>(Insurance Name & ID Number)</i>	<input type="checkbox"/> No Insurance

**Flu Mist is not being offered this year based on CDC recommendations.
 We apologize for any inconvenience this may cause.**

SCREENING FOR FLU VACCINE ELIGIBILITY

If the answer to any question is "Yes", then we cannot vaccinate in school. Please contact your doctor to discuss options.

1. Any serious allergy to eggs?	Yes	No
2. Ever had a serious reaction to previous dose of flu vaccine that required medical attention?	Yes	No
3. Ever had Guillain-Barre Syndrome (temporary severe muscle weakness) after receiving flu vaccine?	Yes	No
4. Any allergy to Thimerosal or Latex?	Yes	No

I have answered "NO" to questions 1-4. I have viewed the Vaccine Information Statement(s) at www.immunize.org or viewed a hard copy obtained by calling the Rhode Island Department of Health (401-222-5960).

I understand the benefits and risks of the vaccine.

The injectable flu vaccine should be given to the person named above for whom I am authorized to make this request. I understand that I can review a Notice of Privacy Practice at the time of vaccination.

Signature of Parent/Guardian/Patient _____ **Date** _____

Print Last Name _____ **Print First Name** _____

FOR ADMINISTRATIVE USE ONLY **VIS Date: 8/7/2015**

Vaccine	Route	Manufacturer	Lot No.	Signature of Vaccine Administrator _____
Influenza	RA LA			Date vaccination and VIS given: ____/____/____