

**2019-2020 Injectable Influenza Vaccine Consent and Screening Form**  
**Information about Child to Receive Vaccine (please print)**

STUDENT'S NAME (Last)		(First)	(M.I.)	STUDENT'S DATE OF BIRTH: month _____ day _____ year _____	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	STUDENT'S AGE:	STUDENT'S GENDER: M / F
ADDRESS				PARENT/GUARDIAN DAYTIME PHONE NUMBER:	
CITY: WALPOLE	STATE: MA	ZIP: 02081			

**Screening for Vaccine Eligibility**

Information to determine if your child should receive 0, 1 or 2 doses of flu vaccine

Children younger than 9 years may need two doses. If your child is 8 years old or younger, answer the other questions in this box.

1. How many total doses of flu vaccine has your child **ever** received before July 1, 2019?

No doses     Only 1 dose     2 or more doses

2. Has your child received flu vaccine this flu season (since July 1, 2019)?     No     Yes

If yes, please tell us the number of doses and dates of vaccination.     1 dose     2 doses

**Dose 1:** Date received: month \_\_\_\_\_ day \_\_\_\_\_ 2019    **Dose 2:** Date received: month \_\_\_\_\_ day \_\_\_\_\_ 2019

The following questions will help us to know if your child can get the seasonal influenza vaccine. If you answer "NO" to all four of the following questions, your child will receive the influenza vaccine. If you answer "YES" to one or more of the following four questions, your child may be able to get the seasonal influenza vaccine. Please mark YES or NO for each question.

	YES	NO
1. Has your child ever had a serious reaction to a flu vaccine in the past?		
2. Has your child ever had a serious allergic reaction after eating eggs?*		
3. Does your child have an allergy to gentamicin, neomycin, polymycin or gelatin?		
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

**Parent/Guardian Consent**

**CONSENT FOR CHILD'S VACCINATION:**

I have read or had explained to me the 2019-2020 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

**I GIVE CONSENT** to the Walpole Board of Health and its staff for my child named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then you child will not be vaccinated)

**Signature of Parent/Legal Guardian** \_\_\_\_\_

Date: month 10 day 22 year 2019

**Vaccination Record**  
FOR ADMINISTRATIVE USE ONLY

Vaccine	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
Influenza Fluzone Quadrivalent (IIV4)	IM L / R Arm	10/22/2019	Sanofi Pasteur	Expired: 06/30/2020	Patricia Fisher, RN

## 2019- 2020 Injectable Influenza Vaccine (Flu Shot) Consent

**Permission to Share Information:** Complete only if you consented to have your child receive flu vaccine. This information will be shared to ensure that your child is appropriately vaccinated. You may refuse to sign this authorization to share information. Refusal to sign will not affect your child's ability to obtain vaccine.

I, \_\_\_\_\_, give permission to the individual and/or entity that administered the 2019 -  
(Parent or Guardian Print your name)

2020 influenza vaccine to my child to share copies of the 2019 – 2020 flu vaccine consent form and vaccination record with my child's school; health care provider; Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2019 - 2020 seasonal influenza consent form and vaccination record with each other.

### My child's school:

Name: \_\_\_\_\_ City or town: Walpole, Massachusetts

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
- This permission expires at the end of the 2019 - 2020 school year.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time, by sending written notification to:

Walpole Health Department, 135 School Street, Walpole, MA 02081

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.



\_\_\_\_\_  
Signature of Parent or Guardian

Date: 10/22/2019

Permission to share is compliant with HIPAA and FERPA requirements.

**To help us determine if your child is eligible to receive vaccines from the Vaccines for Children Program, please check one of the boxes below.** Your child will receive flu vaccine whether or not they are eligible for the Vaccines for Children Program.

- My child is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid)
- My child does not have health insurance
- My child is American Indian (Native American) or Alaska Native
- My child has health insurance and is not American Indian (Native American) or Alaska Native