NEW MEXICO DEPARTMENT OF HEALTH

SCHOOL INFLUENZA (FLU) IMMUNIZATION CONSENT

Public Health Division **SKIIP 2015-16**

For school office use: Place sticker/stamp with school address

If you would like the vaccine given at school, fill in this form completely and legibly, including complete insurance information and return by ____________ (date) to the school nurse

School name: ____________ Grade: ______ Teacher: ____________ Student ID#: ____________

Student's legal last name: ____________ First name: ____________ Middle name: ____________

Mailing address: ____________ Zip: ________ Daytime phone: ____________

Birth Date: ____/____/____ (Month / day / year) Age: ____ Mother's maiden (birth) name: ____________ (first name and last name)

Race: ☐ American Indian/Native American/Alaskan Native ☐ Asian ☐ Other ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Gender: ☐ Male ☐ Female

INSURANCE INFORMATION—Fill in appropriate category—REQUIRED

Centennial Care/Medicaid:

☐ Blue Cross Blue Shield ☐ Molina Healthcare
☐ United Healthcare ☐ Presbyterian

Centennial Care (Medicaid) #____________
Member ID / Patient/Policy #____________

☐ **No health insurance**

Private/Commercial insurance:

☐ Blue Cross Blue Shield ☐ Presbyterian
☐ United Healthcare
☐ Other insurance: ____________ (insurance company name)

Policy/Member/ID #____________ Group #____________

Responsible party____________ ____________ Date of birth

MEDICAL SCREENING QUESTIONS—REQUIRED

Yes	No	Don't know	
☐	☐		1) Does your child have asthma/wheezing or has your child ever taken asthma medication?
☐	☐		2) Does your child have any of the following? Diabetes, anemia, lung disease, cerebral palsy, kidney, liver or heart disease, seizures, pregnancy, or weakened immune system
☐	☐		3) Is your child allergic to eggs?
☐	☐		4) Has your child ever had a serious reaction to flu vaccine in the past, or developed Guillain-Barré syndrome?
☐	☐		5) Is your child allergic to arginine, gentamicin sulfate, neomycin, gelatin, or MSG?
☐	☐		6) Is your child on long-term aspirin therapy?
☐	☐	☐	7) Has your child received any other vaccines in the past 4 weeks? If yes, which ones and date given ____________
☐	☐	☐	8) If your child is under 9 years old: Has your child received at least two doses of seasonal flu vaccine in their lifetime? (not H1N1-only vaccine)

Intranasal

Injectable

YOUR CONSENT IS NEEDED: I have viewed the 2015-16 Intranasal Influenza Vaccine Information Statement http://www.cdc.gov/vaccines/hcp/vis/vis-statements/flulive.pdf and/or the 2015-16 Injectable Influenza Vaccine Information Statement http://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf (see QR codes) or requested hard copies obtained by contacting the school nurse. I understand the benefits and risks of influenza vaccine and request that the influenza vaccine be given to the person above for whom I am authorized to make this request. **If the person above for whom I am authorized to make this request is less than 9 years old and it is determined that a 2nd dose is needed, I also consent for a 2nd dose of vaccine to be given if offered through the school.** Unless I sign a statement signifying otherwise, I allow immunization information to be entered into the New Mexico Statewide Immunization Information System (NMSIIS) and be released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status. **I will contact the school nurse to withdraw this consent if this child is immunized before the date of the school clinic.** The DOH Privacy Policies are available at http://nmhealth.org/hipaa.shtml and will be given to all patients when they receive an immunization.

Signature of parent/legal guardian____________ Date____________

Print name of parent/legal guardian *(print legibly in all caps)*____________

For clinic use (this section must be completed by the medical provider)

	Dose #1 (*VIS date: 2015-2016*)	Dose #2 (*VIS date: 2015-2016*)
Dose #1 VFC ID# ________ Date data entry completed ________ **Dose #2** VFC ID# ________ Date data entry completed ________	Date vaccinated ________ VACCINE: ☐ FluMist® MedImmune ☐ IIV Fluarix GSK ☐ Other ________ Lot # ________ Exp. date ________ Site of administration: ☐ Intranasal ☐ R Deltoid ☐ L Deltoid ☐ Other________ Provider signature & credentials________ Co-signature & credentials________	Date vaccinated ________ VACCINE: ☐ FluMist® MedImmune ☐ IIV Fluarix GSK ☐ Other ________ Lot # ________ Exp. date ________ Site of administration: ☐ Intranasal ☐ R Deltoid ☐ L Deltoid ☐ Other________ Provider signature & credentials________ Co-signature & credentials________