Time In at Registration		Medical Screener Initials

Montgomery County Department of Health and Human Services
School Health Services

Consent for Seasonal Flu Vaccination (IIV)
AGE THREE to 18 YEARS

Dear Parent / Guardian;
Please complete this form if you want your child to receive seasonal flu vaccine. Parents/guardians or authorized adult must be present at the time of vaccine administration.

Child's Last Name:	Child's First Name:	Age:	Grade:
Address:	**Home Phone:** **Cell Phone:** **Work Phone:**	Date of Birth:	
Did your child receive at least 2 doses of influenza vaccine before July 2018? ☐YES ☐NO			

For maximum protection against influenza the Centers for Disease Control (CDC) recommends that children under 8 years old, who are getting seasonal influenza vaccine for the first time, receive a second dose in 4 weeks.

If you answer YES to ANY of the questions below, your child is NOT eligible to receive the seasonal flu vaccine at this site. Please take your child to their health care provider.
If you answer NO to ALL of the questions and would like your child to receive the seasonal flu vaccine, please sign below.

1. Is your child sick today?	☐YES	☐NO
2. Does your child have an allergy to egg products other vaccine components?	☐YES	☐NO
3. Has your child ever had a serious reaction to an influenza vaccine in the past?	☐YES	☐NO
4. Does your child have a history of Guillian-Barre syndrome?	☐YES	☐NO

Flu Vaccine cannot be administered to any child who is ill on the day of the vaccination clinic.

Statement of Consent:
I have received and read the Vaccine Information Statement (VIS) about the seasonal flu vaccine. I have had the chance to ask questions that were answered to my satisfaction. I understand that this vaccine is approved for healthy children and I have reviewed the reasons some children should not get the seasonal flu vaccine. None of these reasons apply to my child. I request that this vaccine be given to my child for whom I am authorized to make this request.

Print Name parent / guardian: _____Signature parent / guardian: _____Date:_____

Vaccines for Children questionnaire (your responses will not impact your ability to receive vaccines at this mass clinic).

- ☐ **IS ENROLLED IN MEDICAID – MA# _____**
- ☐ **HAS NO HEALTH INSURANCE** ☐YES ☐NO
- ☐ **HAS HEALTH INSURANCE THAT DOESN'T COVER VACCINES** ☐YES ☐NO
- ☐ **IS AMERICAN INDIAN OR ALASKAN NATIVE** ☐YES ☐NO

* * * * * * Office Use Only * * * * * *

Vaccine	Mfgr/ Lot #	Exp. date	Dose/ Route	VIS Date	Time of Vaccination
Influenza			0.5 ml IM	08/07/2015	

2nd Dose Required if less than 8 years old and has not previously received two doses of flu vaccine prior to July 1 of this year. Doses do not need to have been given in the same year or season.	Yes	No

Vaccine administered by: _____ Date: _____
SCHN Signature

Rev. 09/12/2018