

Flu Vaccine Consent Form

for students age 11-18

Please Print

Student Name: _____ Date of Birth: _____ Age: _____

Sponsor Name: _____ Sponsor SS# _____

Home phone: _____ Work: _____ Cell: _____

Before your child can receive FluMist® or Flu Fluzone®, you must read this information sheet attached and answer the questions below. FluMist® should only be administered to people ages 2-49 years old who are healthy and not pregnant. Certain people must not receive FluMist®. **You must answer each question below to determine if your child is eligible to receive FluMist®.** If your child is not eligible to receive FluMist® they will be administered Fluzone® Influenza Vaccine. A copy of the vaccine administered will be given to your child to bring home to you. The health care professional will keep this questionnaire and any information collected in a confidential manner.

Please CHECK YES or NO for all questions below regarding the student.	YES	NO
Has your child received a "FLU" vaccination before (either Flu Shot or FluMist)?		
Has your child received a vaccine within the past 30 days? Name of Vaccine(s): Date Given: your child received a "FLU" vaccination before (either Flu Shot or FluMist)?		
Does your child currently have a respiratory illness or a fever?		
Is your child taking any prescription medicines to prevent or treat influenza?		
Does anyone living with your child have a compromised immune system?		
Is your child allergic to eggs, egg proteins, gentamicin, gelatin, MSN or arginine?		
Does your child have any disease of the lungs, including chronic bronchitis, emphysema or cystic fibrosis?		
Does your child have a history of asthma, reactive airway disease, or wheezing?		
Does your child have diabetes or other metabolic diseases/disorders?		
Does your child have kidney diseases?		
Has your child ever had a reaction to an injection? If yes, please describe:		
Is your child pregnant or nursing?		
Does your child have a blood disease like sickle cell disease or thalassemia?		
Does your child have heart disease (angina, congestive heart failure) or has your child ever had a heart attack?		
Did your child ever have Guillain-Barre syndrome or active neurological disease?		
Is your child on long-term aspirin therapy?		
Does your child have a disease such as cancer, lupus, HIV/AIDS, or do they take a medication that lowers the body's resistance to infection?		
Does your child have close contact with anyone who has had a bone marrow transplant in the last 6 months?		
Please list any allergies:		
Additional Notes (use back of page if necessary):		

I have read the attached information about FluMist®/Fluzone® and have truthfully answered all of the questions on this form. I request for administration of Influenza Vaccine for the above named recipient. I am aware that the receiver of this vaccine is currently not pregnant nor will become pregnant within four weeks of receiving this vaccine. My child is over the age of eleven on the date of the vaccine administration. I have read information about the vaccine and special precautions on the Vaccine Information Sheet. I request and voluntarily consent that the vaccine be given to the person above of whom I am parent or legal guardian and acknowledge that no guarantees have been made concerning the vaccine's success. I hereby release DODEA and USAMH, their affiliates, employees, directors, and officers from any and all liability arising from any accident, act of omission or commission, which arises during vaccination.

My signature below indicates my permission for FluMist® or Fluzone® to be given to the child named below, and I am the Child's parent or legal authority with authority to consent to vaccination.

Parent Signature

Date



*Your child (over the age of eleven) must bring this form to Heidelberg Middle School (MPR) on 31 OCT 08 between 1000-1400 in order to receive the flu vaccine. Students without the consent form will not be given the flu vaccine.

PRIVACY ACT NOTICE

AUTHORITY: Sections 113, 136 and 2164 of title 10, and 921-932 of title 20 of the United States Code. PRINCIPAL PURPOSE: To promote student's health for learning.
ROUTINE USE (S): Disclosures are authorized by 5 U.S.C. 552a(b) of the Privacy Act within DoD and outside DoD as a routine use pursuant to DoD Blanket Routine Uses set forth at <http://defenseink.mil/privacy/noticesosd>, authorized by 5 U.S.C. 552a(b)(3).

DISCLOSURE: Voluntary. Without this information school personnel will not be able to provide appropriate education and health services.