STUDENT Vaccination Consent Form—
FLU NASAL SPRAY

STUDENT'S NAME (Last)	(First)	(M. I.)	**STUDENT'S DATE OF BIRTH** / /
PARENT/GUARDIAN'S NAME (Last)	(First)	(M. I.)	**STUDENT'S GENDER (Circle)** Male Female

ADDRESS	**PHONE** DAYTIME: CELL: HOME:

SCHOOL NAME	**GRADE**	**HOMEROOM TEACHER'S NAME**

STUDENT'S DOCTOR'S NAME	**PRIMARY CLINIC**

STUDENT'S HEALTH INSURANCE: ☐ (Circle one) - Medicaid / MA / Blue Plus / UCare / Prime West
☐ Private Insurance
☐ No Insurance

The following questions will help us to determine if your child may receive the **FLU NASAL SPRAY** (Live, intranasal influenza vaccine). Please mark **YES** or **NO** for each question.

		YES	**NO**
1.	Has your child received a flu vaccine in the past?	☐	☐
2.	Has your child ever had a serious allergic reaction to eggs or to a component of any flu vaccine?	☐	☐
3.	Has your child ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4.	Has your child ever had Guillain-Barre Syndrome (a serious nervous system disorder)?	☐	☐
5.	Does your child have a long-term health problem such as heart disease, kidney disease, lung disease such as asthma, metabolic disease such as diabetes, or blood disorders such as anemia?	☐	☐
6.	Does your child have a weakened immune system caused by cancer, cancer treatment such as x-rays or drugs, HIV/AIDS, or other disorder; is your child taking other drugs such as steroids that weaken the immune system?	☐	☐
7.	Does your child live with or have close contact with anyone with a severely weakened immune system requiring care in a protected environment?	☐	☐
8.	Is your child receiving aspirin or other aspirin-containing medication?	☐	☐
9.	Is your child taking any prescription medicines to prevent or treat flu (i. e. Tamiflu® or Relenza®)?	☐	☐
10.	Is the person to be vaccinated pregnant or could she become pregnant within the next month?	☐	☐
11.	Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐	☐

CONSENT FOR CHILD'S VACCINATION: I have received and read the 2010 Vaccine Information Statement for the FLU NASAL SPRAY (Live, Intranasal Influenza Vaccine). The FLU NASAL SPRAY should not be given within 4 weeks of a MMR (measles/ mumps/rubella) or varicella (chickenpox) vaccine, so I will inform my child's doctor that my child will be receiving a FLU NASAL SPRAY vaccine at school between September—December 2010. I understand the risks and benefits , and give consent for my child, named at the top of this form, to receive the FLU NASAL SPRAY. I also consent to having information regarding my child's influenza vaccination shared with my child's doctor and my child's health insurance company.

→ Signature / Parent or Legal Guardian _____ Date: _____ / _____ / _____

For Administrative Use Only

Reason **FLU NASAL SPRAY** **NOT** given:
- ☐ Student had temperature of 100.5º or higher
- ☐ Student's consent form incomplete—parent / guardian could not be contacted
- ☐ Student refused **FLU NASAL SPRAY**
- ☐ Student absent
- ☐ Other: _____