FLU SHOT *Clinic*

The Republic School District, in cooperation with Jordan Valley Community Health Center, is offering free seasonal flu vaccines to Republic students, as supply allows.

The following conditions would prevent your child from receiving a flu vaccine: allergy to vaccine components and moderate or severe illnesses.

If you are interested in your child receiving the inactivated influenza vaccine (flu shot) at school on the date below, please complete and sign the consent form on the other side of this paper and return to your school nurse by October 20th.

If you have questions please contact your school nurse.

CLINIC DATES:

10/26: RMS, EC, Lyon & Sweeny

10/28: RHS, McCulloch, Price & Schofield

10/20 IS THE DEADLINE TO REGISTER

Date of Service: ______________

Influenza Vaccine Consent

Name: ______________________ **Date of Birth:** ______________________

SS#: ______________________ **Medicaid # (if applicable):** ______________________

Address: ______________________ **City:** ______________ **Zip:** ______________

Insurance Plan: ______________________ **Policy #:** ______________ **Group #:** ______________

Please check which answer applies if the patient is 17 years of age or younger

___ he/she is enrolled in Medicaid ___ he/she has insurance, but it does not cover vaccinations

___ he/she has no insurance ___ he/she is an Alaskan Native or Native American ___ none of the above

Please circle which answer applies:

1.	Are you sick today? (Do not include mild cold symptoms or seasonal allergies.)	***Yes***	***No***	***Unsure***
2.	Have you ever had a serious reaction to chicken eggs including: hives, swelling of the lips or tongue, or difficulty breathing?	***Yes***	***No***	***Unsure***
3.	Have you ever had a serious reaction after receiving a previous dose of an influenza vaccine?	***Yes***	***No***	***Unsure***
4.	Have you ever had a serious reaction after receiving a vaccine?	***Yes***	***No***	***Unsure***
5.	Have you ever been diagnosed with heart disease, lung disease, asthma, kidney disease, metabolic disease (diabetes), anemia, or other blood disorder?	***Yes***	***No***	***Unsure***
6.	I have been diagnosed with leukemia, AIDS, or any other immune system problem?	***Yes***	***No***	***Unsure***
7.	Do you take cortisone, prednisone, other steroids, or anticancer drugs; or had x-ray treatments?	***Yes***	***No***	***Unsure***
8.	Have you had a seizure, brain, or other nervous system problem?	***Yes***	***No***	***Unsure***
9.	During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	***Yes***	***No***	***Unsure***
10.	**Females:** Are you pregnant or is there a chance you could become pregnant in the next month?	***Yes***	***No***	***Unsure***
11.	Have you received any vaccinations in the last 4 weeks?	***Yes***	***No***	***Unsure***
12.	Are you 50 years or older?	***Yes***	***No***	***Unsure***

Please Read and Sign Below

I have been given a copy of and have read or have had explained to me the information in the "Vaccine Information Statement(s)" for the influenza vaccine. I have had the opportunity to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the flu vaccine. I agree to allow Jordan Valley Community Health Center to communicate with the school district, health care provider, or health department regarding vaccination received if needed. I also agree that vaccinations received may be entered into MOHSAIC, the computerized immunization database for the state of Missouri.

Signature: ______________________________ **Date:** ______________________

(Signature of person authorized to make request for immunization)

Staff to Complete this Section

Manufacture & Lot #: ______________ **Exp Date:** __________ **Shot Location: Deltoid Left Right**

Consent Signed: _____ **VIS Sheet Given:** _____ **Staff Initials/Title:** __________ **Date & Time Given:** __________