STUDENT Vaccination Consent Form - FLU NASAL SPRAY

(PLEASE PRINT LEGIBLY IN CAPITAL LETTERS USING BLACK OR BLUE INK)

STUDENT'S LAST NAME	STUDENT'S FIRST NAME	MI(S)	STUDENT'S DATE OF BIRTH (M M / D D / Y Y)
			/ /

STUDENT'S ADDRESS

STUDENT IS A: ☐ TWIN ☐ TRIPLET

CITY	STATE	ZIP CODE	HOME PHONE NUMBER ( ) -

STUDENT'S GENDER: ☐ MALE ☐ FEMALE

PARENT/GUARDIAN'S NAME (LAST)	(FIRST)	DAYTIME PHONE	CELL PHONE

SCHOOL NAME	GRADE (SELECT ONE "●")
HOMEROOM TEACHER'S NAME (LAST, FIRST)	JRK K 1 2 3 4 5 6 7 8 9 10 11 12
STUDENT'S DOCTOR'S NAME (LAST)	(FIRST)

STUDENT'S HEALTH INSURANCE: (SELECT ONE "●") The Stop Flu at School program is **FREE**. Your insurance company will NOT be billed.

○ HMSA – PRIVATE ○ KAISER – PRIVATE ○ UNITEDHEALTHCARE – PRIVATE ○ ALOHACARE ○ UHA ○ HMA ○ OHANA
○ HMSA – QUEST ○ KAISER – QUEST ○ UNITEDHEALTHCARE – QUEST ○ CHAMPUS/TRICARE ○ MDX ○ HMAA ○ OTHER ○ NO INSURANCE

INSURANCE POLICY NUMBER

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

		YES	NO
1.	Has your child ever had a serious allergic reaction to eggs or to a component of any flu vaccine?	○	○
2.	Has your child ever had a serious reaction to a previous dose of flu vaccine?	○	○
3.	Has your child ever had Guillain-Barré Syndrome (a serious nervous system disorder)?	○	○
4A.	Has your child ever had **WHEEZING or ASTHMA**?	○	○
B.	Does your child have a long-term health problem such as heart disease, kidney disease, lung disease, cognitive, neurologic or neuromuscular disease, liver disease, metabolic disease such as diabetes, or blood disorders such as anemia?	○	○
5.	Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, has he/she taken medications that weaken the immune system, such as cortisone, prednisone, other steroids or anticancer drugs; or has he/she had radiation treatments?	○	○
6.	Does your child live with or expect to have close contact with anyone with a severely weakened immune system requiring care in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	○	○
7.	Is your child receiving aspirin therapy or other aspirin-containing medication?	○	○
8.	Is your child taking any prescription medicines to prevent or treat flu (i.e., Tamiflu® or Relenza®)?	○	○

If you answered YES to any question, left any question blank, or you are unsure of the answer to any of the questions above, your child will not receive the Flu Nasal Spray through the school vaccination program, but may be able to receive a Flu Shot (see GREEN Flu Shot Consent Form).

CONSENT FOR CHILD'S VACCINATION: I have received and read the 2015-16 Vaccine Information Statement for Flu Vaccine, Live, Intranasal. The **FLU NASAL SPRAY** should not be given within 4 weeks of a live virus vaccine (e.g., MMR, MMRV, varicella), so I will inform my child's doctor that my child will be receiving a **FLU NASAL SPRAY** vaccine at school between October – November 2015. I understand the risks and benefits, and give consent to the State of Hawaii Department of Health and its authorized staff for my child, named at the top of this form, to receive the **FLU NASAL SPRAY** and to share information regarding my child's influenza vaccination with my child's doctor and my child's health insurance company. I agree to waive and release any claims against the State, all contributory members of the Hawaii Association of Health Plans, and all other program sponsors, related to or arising from the Stop Flu at School Program. In addition, I have received information regarding the Hawaii Immunization Registry (see reverse side).

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

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Dose Size	Route	Vaccine Manufacturer	Lot Number	Expiration Date	VIS Publ. Date	Name, Address, & Title of Vaccine Administrator
Live, intranasal influenza vaccine	/ /	0.2 ml	Intranasal	MedImmune		/ /	/ /	

Reason **FLU NASAL SPRAY** **NOT** given:
○ Student had temperature of 100.5º or higher
○ Student refused **FLU NASAL SPRAY**
○ Student's consent form incomplete
○ Student absent
○ Other: _____