STUDENT Vaccination Consent Form - FLU SHOT

(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 IS A: ☐ TWIN ☐ TRIPLET

STUDENT'S ADDRESS

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 "●")
	JRK K 1 2 3 4 5 6 7 8 9 10 11 12
HOMEROOM TEACHER'S NAME (LAST, FIRST)	
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 Shot** (inactivated 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)?	○	○

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 Shot (inactivated influenza vaccine) through the school vaccination program. Please talk to your child's doctor.

CONSENT FOR CHILD'S VACCINATION: I have received and read the Vaccine Information Statement for Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*, dated 8/7/2015. 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 SHOT** 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).

Parent or Legal Guardian Printed Name (Last, First) _____ Parent or Legal Guardian Signature _____ Date: ____/____/____

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Dose Size	Site	Route	Vaccine Manufacturer	Lot Number	Expiration Date	VIS Publ. Date	Name, Address, & Title of Vaccine Administrator
Inactivated influenza vaccine	/ /	0.5 ml	RA LA	IM			/ /	/ /	

Reason **FLU SHOT NOT** given:

○ Student had temperature of 100.5º or higher
○ Student's consent form incomplete
○ Student refused **FLU SHOT**
○ Student absent
○ Other: _____