STUDENT Vaccination Consent Form—
FLU SHOT

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
- ☐ My insurance does not cover flu vaccine or it goes to my deductible

The following questions will help us to determine if your child may receive the **FLU SHOT** (inactivated 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)?	□	□

CONSENT FOR CHILD'S VACCINATION: I have received and read the Vaccine Information Statement for the FLU SHOT (Inactivated Influenza Vaccine). I understand the risks and benefits and give consent for my child, named at the top of this form, to receive the FLU SHOT. 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: _____ / _____ / _____