

KANAWHA-CHARLESTON HEALTH DEPARTMENT
108 Lee Street, East, Charleston WV 25301
2011 – 2012 Seasonal Influenza Vaccine

INTRANASAL VACCINE CONSENT FORM

Student's Name _____		
(Last)	(First)	(Middle Initial)
Current Address _____		
(Street Address)		

(City)	(State)	(Zip)
Date of Birth _____	Age _____	Gender <u>M</u> <u>F</u>
MO/Day/Year		Race _____
		(optional)
School Name _____	Grade _____	Teacher/Homeroom _____

FLU INTRANASAL SCREENING FORM

Please review the Vaccine Information Sheet **BEFORE** completing this form. On the day of the vaccination clinic, If the child is ill with a fever, the nurse may decide to postpone the vaccination. Form must be completed by a parent or legal guardian.

	YES	NO
1. Has your child ever received a Seasonal or H1N1 flu vaccine before? a. If YES, has your child received the shot _____ or intranasal _____ or both _____ b. If NO, your child has never had a flu vaccine, does he/she have any allergies? Describe _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Did your child have a reaction to an influenza vaccine before? a. If YES, Describe _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever been paralyzed with a disease called Guillain-Barré Syndrome (GBS)? a. If YES, Describe _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child have a severe allergy to eggs? a. If YES, check with your doctor to see if your child can receive the flu vaccine. (If your child can eat eggs, they can receive the vaccine).	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child have an allergy to latex? a. If YES, Describe _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child have any long-term health problems or any conditions that weaken the immune system? a. If YES, Describe _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child have asthma or wheezing?	<input type="checkbox"/>	<input type="checkbox"/>
8. Is your child pregnant or could become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>
9. Is your child taking medicines that contain aspirin?	<input type="checkbox"/>	<input type="checkbox"/>
10. Is your child taking any antiviral medications? a. If YES, list _____ Example: Amantadine, Rimantadine, Relenza, Tamiflu	<input type="checkbox"/>	<input type="checkbox"/>
11. Does your child live with or have close contact with someone severely compromised and in protective isolation?	<input type="checkbox"/>	<input type="checkbox"/>
12. Has your child received any other vaccinations in the past 4 weeks? a. If YES, list _____	<input type="checkbox"/>	<input type="checkbox"/>

Parent or Legal Guardian _____ **Signature** _____ **Date** _____

PLEASE TURN PAGE OVER AND COMPLETE THE OTHER SIDE

Children 18 and under may qualify for state-supplied vaccine at a reduced rate. If the student is 18 or under, please complete this section of the form. If the student is 19 or older, please skip to next section.

Parent/Guardian _____
Last name First MI

This child is privately insured Yes No

This child is enrolled in WVCHIP and qualifies for state-supplied vaccine Yes No

This child qualifies for Immunization through the VFC Program because he/she (check only one):

Is enrolled in Medicaid

Does not have health insurance

Is an American Indian or Alaskan Native

Is underinsured (has health insurance that does not pay for vaccinations)

Primary Physician's Name _____
Last name First MI

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

The KCHD Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice of Privacy Practices is subject to change. To obtain a copy of our Notice, you may visit our website at www.kchdvw.org or by calling (304) 348-8080. By signing this form, you acknowledge that the KCHD Notice of Privacy Practices was made available to you.

CONSENT

You must be at least 18 years of age to sign. If under age 18, a parent or guardian's signature is required. I have read or had explained to me the 2011-12 Vaccine Information Statement for the 2011-12 Influenza vaccine and understand the risks and benefits. I give consent for my child named at the top of this form to be vaccinated with this vaccine.

INSURANCE INFORMATION

Name of Primary Insurance: _____

Policy Holder's Name _____	Relationship To Policy Holder _____
(Last)	(First)

Policy Holder Date of Birth: _____ **Policy ID Number:** _____ **Group # (if any)** _____

Signature of Parent or Legal Guardian **Date**

Health Department Use Only

Medical Screener Signature _____
 Date _____

Type of vaccine:	Intranasal	Manufacturer:	Medimmune	Lot#	
Date Vaccinated:		Vaccinator Signature:			