



# 2015-16 STUDENT INFLUENZA VACCINATION CONSENT FORM



## IIV & LAIV or LAIV ONLY

Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Gender:  M  F

If minor - parent/guardian's name: \_\_\_\_\_  
Last First M.I.

Parent/Guardian's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Parent's SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
*optional*

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Grade: \_\_\_\_\_ Home Room Teacher: \_\_\_\_\_ School: \_\_\_\_\_

**IMPORTANT** Parent/Guardian Phone # Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Please check YES or NO to all of the questions below to determine if your child can receive the Intranasal Influenza Vaccine (FluMist® – “nasal spray”) or the Inactivated Influenza Vaccine (“flu shot”). The nurse giving the vaccine will review this information on the day of the vaccine clinic.

	YES	NO
1. Has your child ever had a serious allergic reaction to any component of any flu vaccine (eggs, gentamicin, gelatin, and arginine)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Has your child ever had a serious reaction to a previous dose of flu vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had Guillain-Barré syndrome (GBS, i.e., progressive ascending paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>

**If you answered YES to any of questions 1, 2 or 3 above about a serious allergy, reaction or GBS, flu vaccine may not be safe for your child and s/he WILL NOT receive a flu vaccine. If you answered NO to questions 1, 2 or 3, please continue below.**

4. If your child is between 2 – 4 years, has a healthcare provider ever told you that your child had a wheezing or asthma within the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does your child have a long-term health problem such as heart disease, kidney or liver disease, lung disease (e.g. <b>asthma</b> ), metabolic disease (e.g. <b>diabetes</b> ), or blood disorders (e.g. <b>anemia</b> )?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child have a weakened immune system because of cancer, cancer treatment (e.g. x-rays or drugs), HIV/AIDS, other disorders, or medicine (e.g. high dose steroids)?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child live with or expect to have close contact with a severely immunosuppressed person requiring a protective environment (e.g., an isolation room of a bone marrow transplant unit)?	<input type="checkbox"/>	<input type="checkbox"/>
8. Is your child taking aspirin or other aspirin-containing products?	<input type="checkbox"/>	<input type="checkbox"/>
9. Is your child taking any prescription medications to prevent or treat flu?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has your child received a MMR (measles/mumps/rubella) and/or varicella (chickenpox) vaccination within the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
11. Is your child pregnant or could she become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>

**If you answered YES or left blank any questions from # 4 through # 11 or if your child is younger than 2 years old, your child WILL NOT receive FluMist®, but she/he CAN RECEIVE the flu shot.**

### NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:

1. If any VDH health care professional, worker or employee should be directly exposed to your child's blood or body fluids in a way that may transmit disease, your child's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. Under Va. Code § 32.1-45.1(A), you are deemed to have consented to the release of the test results to the person exposed.
2. If your child should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the test.

### Office of Privacy and Security Authorization for Disclosure of Protected Health Information

As the person signing this authorization, I understand that I am giving permission to the Virginia Department of Health (VDH) to disclose personal health information to the person(s) or organization(s) I have indicated.

- I understand the provision of treatment to me cannot be conditioned on my signing of this authorization.
- Any health information redisclosed by me or my child will no longer be protected by this authorization.

- The original or a copy of the authorization shall be included with my child's medical record.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken prior to my request to withhold my medical record. The request must be in writing and will be effective upon delivery to the provider in possession of my medical records.
- I authorize VDH to disclose my child's health information to his/her primary care physician and school.
- I understand that this record will be retained until my child reaches 21 years of age.
- I authorize VDH to release records necessary to support the application for payment by Medicare, Medicaid, and other health care benefits. I request the third party payer to pay any authorized benefits to VDH on my behalf.

Please check box if you wish to receive a copy of the Virginia Department of Health Privacy Rights.

**Insurance\*:** Please answer the following: This information is required for federal funding purposes for VFC vaccines.

**\*Note:** Vaccines will be provided to your child without cost to you if your child is eligible for the Vaccines for Children Program. If your child is covered by a private health insurance plan, the Department is required by law to seek reimbursement for all allowable costs associated with the provision of the vaccine.

My child: ( ) is **not** insured (by private insurance, Medicaid, or FAMIS)  
 ( ) is American Indian or is an Alaska Native  
 ( ) has Medicaid - Medicaid #: \_\_\_\_\_  
 ( ) has FAMIS - FAMIS #: \_\_\_\_\_  
 ( ) has other insurance not listed above (specify plan) \_\_\_\_\_  
 Policy ID # \_\_\_\_\_ Policy holder's name \_\_\_\_\_

Attach a copy of the front & back of insurance card or provide the following information:

Insurance company address \_\_\_\_\_  
 Insurance company phone number \_\_\_\_\_

**CONSENT FOR CHILD'S VACCINATION: In October 2015, will your child be less than 9 years of age? No  Yes**

Please complete the next set of questions and sign.

My child is **under 9 years of age** and:

- has NEVER been vaccinated against the flu. **Note: Your child will require 2 doses this year.**
- has not been vaccinated with at least 2 doses of seasonal influenza vaccine before July 1, 2015. **Your child will require 2 doses this year.**

I have read the 2015 Vaccination Information Statements (VIS) for the influenza shot and for the nasal spray. I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to get vaccinated with this vaccine. I prefer my child be given the (please check one)  flu shot,  flu mist. I understand the decision on the type of vaccine administered will depend on my child's history. **If needed, I give my consent for my child to receive the second dose 4 weeks after the first.**

Signature of Parent or Legal Guardian:  \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**I understand that the Virginia Department of Health will not release private medical records unless authorized above or to continue care.**

\_\_\_\_\_  
 Please Print Your Name Signature Date

**Please send a copy of my child's immunization record to her/his doctor at the following address:**

Doctor's Name \_\_\_\_\_ Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

HEALTH DEPARTMENT USE ONLY

Date	Item code	Cost type	Lot Number	Vaccine Administration Site	Provider #
		VFC Chargeable		RA LA NAS	
		VFC Chargeable		RA LA NAS	
Comments					
Provider Name/Signature and Date					