School Cowden **FLU IMMUNIZATION CONSENT FORM** Grade_____

Teacher_____

The Springfield School District, in cooperation with Jordan Valley Community Health Center is offering **seasonal flu vaccine** to any child who qualifies for the **Vaccines for Children (VFC) Program**, as supply allows. If you would like your child to receive the flu vaccine, please complete this form. All vaccines given at these clinics are provided free of charge.

The Inactivated Influenza (FLU Shot) will be administered.

1) QUALIFYING CHILDREN for VFC: Check which applies for your child (at least one must apply):

_____he/she has no insurance
_____he/she has insurance, but it does not cover vaccinations
_____he/she has Medicaid
_____he/she is an Alaskan native or Native American

In addition, for those students with **private insurance coverage** that fully covers vaccinations and therefore not qualifying for VFC, inactivated influenza vaccine (FLU shot) has been provided by Springfield Greene County Health Department, Cox Health, and Mercy Springfield and will be given free of charge. Please **check if your child has private insurance that pays fully for vaccinations (Not Medicaid)**

___ he/she **HAS** private insurance (not Medicaid) that pays fully for vaccinations.

Please review the Vaccine Information Sheet provided for inactivated influenza vaccine. If you have questions about the vaccine that are not answered on the Vaccine Information Sheet, please talk to your school nurse.

2) CHILD'S INFORMATION:

Child's Name:_____ SS#_____ Gender: M F Race_____
Child's Date of Birth:_____ Medicaid No:_____ Language:_____
Child's Mother/Father/Guardian Name:_____ Date of Birth:_____ Phone:_____
Child's Street Address:_____ City_____ Zip:_____

3) PLEASE CIRCLE 'YES' OR 'NO

1. Has your child received a vaccine within the past 30 days? Yes No
   If yes, please list name of vaccine(s):_____
2. Has your child received a flu vaccination before? Yes No
3. Is your child allergic to any part of the vaccine (eggs, egg proteins, gentamicin, gelatin, or arginine)? Yes No
4. Has the child ever had a life-threatening reaction to an influenza vaccine? Yes No
5. Is your child currently receiving aspirin or aspirin-containing therapy? Yes No
6. Does your child have asthma, recurrent wheezing, or active wheezing? Yes No
7. Has your child ever had Guillain-Barré syndrome? Yes No
8. Does your child have any diseases (for example, cancer, lupus, or HIV/AIDS) or take a medication (for example, steroids or chemotherapy) that lowers the body's resistance to infection? Yes No
9. Does your child have any of the following long-term health problems? (CHECK CIRCLE)
   ○ heart disease ○ kidney disease ○ metabolic diseases (for example, diabetes)
   ○ other_____
10. Is your child pregnant or nursing? Yes No
11. Please let us know if your child has close contact with anyone who has a weakened immune system (for example, an individual who has had a bone marrow transplant and is in a negative pressure hospital room). Please describe:
    _____

Allergies/medical alert: _____

4) READ AND SIGN BELOW:

Request for administration of inactivated Influenza (FLU Shot): I have been given the CDC Vaccine Information Statement. I have read this document and have no further questions at this time. I understand that my child will receive the inactivated Influenza (FLU shot) vaccine. I understand the risks and benefits of the inactivated intramuscular influenza vaccines. I request and voluntarily consent that the vaccine be given to the above-named recipient, of whom I am the parent or legal guardian, and I acknowledge that no guarantees have been made concerning the vaccine's success. I understand the side effects and warnings of the vaccine.

Signature of Parent/Guardian _____ Date _____

Office Use only

Date: _____ Name: _____ DOB: _____

Inactivated Flu Vaccine (VIS dtd 08 15 2019)

Vaccine	Mfr	Lot No	Exp Date	Site	Route	NURSE Signature & Credentials
Inactivated Flu	S-P/NOV/GSK				IM	RN/LPN

VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2 Influenza vaccine

CDC recommends everyone 6 months of age and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3 Talk with your health care provider

Tell your vaccine provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**.
- Has ever had **Guillain-Barré Syndrome** (also called GBS).

In some cases, your health care provider may decide to postpone influenza vaccination to a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

- Soreness, redness, and swelling where shot is given, fever, muscle aches, and headache can happen after influenza vaccine.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13), and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's **www.cdc.gov/flu**