**SAMPLE 2020 - 2021 Influenza Nasal Spray Vaccine Consent and Screening Form**

 **Section 1: Information about the student to receive vaccine** (please print):

|  |  |  |  |
| --- | --- | --- | --- |
| Name: (Last, First, MI) | Date of birth: \_\_\_\_\_ \_\_\_\_ \_\_\_\_\_Month Day Year | Age | Sex: (Circle) Male Female |
| Street Address: | Student grade: |
| City: | State:  | Zip: | Phone:( ) |

 **Section 2: Consent**

|  |
| --- |
| **CONSENT FOR CHILD’S VACCINATION:** I have read or had explained to me the Vaccine Information Statement for the influenza vaccine and understand the risks and benefits.  |
| **I GIVE CONSENT** for my child named at the top of this form to get vaccinated with this vaccine. Children younger than 9 years of age may need 2 doses of vaccine. (If this consent is not signed, dated and returned, my child will not be vaccinated.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature of Parent/Legal Guardian Date | **I DO NOT GIVE CONSENT** for my child named at the top of this form to get vaccinated with this vaccine.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_Signature of Parent/Legal Guardian Date  |

**You must return this form to the school whether or not you give consent for your child to receive vaccine.**

 **Section 3: Permission to Share Information\***:Complete only if you consented to have your child receive flu vaccine. This information will be shared to ensure that your child is appropriately vaccinated. You may refuse to sign this authorization to share information.  Refusal to sign will not affect your child’s ability to obtain vaccine.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give permission to the individual and/or entity that administered the 2020 -

 (Print your name)

2021 influenza vaccine to my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to share copies of the 2020 – 2021 flu

 (Print child’s full name)

vaccine consent form and vaccination record with my child’s school and health care provider named below. I also give permission for each of these entities to share the 2020-2021 influenza consent form and vaccination record with each other.

**My child’s health care provider:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**My child’s school:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City or town: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
* This permission expires at the end of the 2020 – 2021 school year.
* If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
* I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
* Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(School/institution/individuals handling withdrawals must insert name and address)

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Parent or Guardian Printed name of Parent or Guardian

 Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed:\_\_\_\_/\_\_\_\_/\_\_\_\_

\*NOTE: In accordance with 105 CMR 220.100, all immunizations will be reported to the Massachusetts Immunization Information System (MIIS). If this immunization clinic actively reports data to the MIIS, please see the accompanying MIIS Factsheet for Parents and Patients, also available at [www.mass.gov/dph/miis](http://www.mass.gov/dph/miis), for information on the MIIS and what to do if you object to your data being shared with other providers in the MIIS. Signing or refusing to sign Section 3 above will not impact the reporting of your child’s immunization information to the MIIS.

 **SAMPLE 2020-2021 Screening for Nasal Spray Influenza Vaccine**

**Complete this side only if you consented to have your child receive flu vaccine.** Answering these questions will help us to know which type of flu vaccine your child should get and whether your child should get 0, 1 or 2 doses of flu vaccine.

**Section 1: Information to determine if your child should receive 0, 1 or 2 doses of flu vaccine.**

**If your child is 9 years old or older, go to Section 2 below.**

**If your child is 8 years old or younger, answer the other questions in this box.**

1. How many total doses of flu vaccine has your child ever received before July 1, 2020?

 **□** No doses **□** Only 1 dose **□** 2 or more doses

2. Has your child received flu vaccine this flu season (since July 1, 2020)? **□ No** **□ Yes**

 If yes, please tell us the number of doses and dates of vaccination. **□** 1 dose **□** 2 doses

 **Dose 1:** Date received: month \_\_\_\_ day \_\_\_\_ 2020 **Dose 2:** Date received: month \_\_\_\_ day \_\_\_\_ 2020

**Section 2: Information to determine if your child should receive the 2020-2021 flu vaccine.**

Please check YES or NO for each question. If you answer “YES” to one or more of the questions, your child will not be able to get flu vaccine in school, unless there is a note from your child’s health care provider saying it is ok for your child to get flu vaccine. If you answer “NO” to these questions, your child will receive the vaccine. If you are not sure of the answers, check with your child’s healthcare provider.

|  |  |  |
| --- | --- | --- |
|  | **NO** | **YES** |
| 1. Has your child ever had a serious reaction to flu vaccine in the past? |  |  |
| 2. Has your child ever had a serious allergic reaction after eating eggs?\* |  |  |
| 3. Does your child have an allergy to gentamicin or gelatin? |  |  |
| 4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine? |  |  |
| 5. Has your child received any vaccine (not just flu) within the past 30 days? If yes, Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date received: month \_\_\_\_ day \_\_\_\_ year\_\_\_\_  |  |  |
| 6. Does your child have asthma?  |  |  |
| 7. Does your child have diabetes (or other type of metabolic disease) or disease of the lungs, heart, kidneys, liver, nerves, or blood? |  |  |
| 8. If your child is younger than 5 years old, has a healthcare provider told you that your child had wheezing or asthma within the last 12 months? |  |  |
| 9. Is your child currently taking aspirin or aspirin-containing medicine? |  |  |
| 10. Is your child receiving or has recently received influenza antiviral medications? |  |  |
| 11. Does your child have a cochlear implant, spinal fluid leak, or no spleen; have a weak immune system (from HIV, cancer, or medicines such as steroids or those used to treat cancer, rheumatoid arthritis, Crohn’s disease, psoriasis, or radiation treatments)? |  |  |
| 12. Is your child pregnant? |  |  |
| 13. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)? |  |  |

\*Please note:

* Experts now say any flu vaccine can be administered to those with a serious allergic reaction to eggs, including anaphylaxis. However, such individuals should be vaccinated in an inpatient or outpatient medical setting where **vaccine administration can be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions**. (Note: this does not apply to Flublok and Flucelvax which are egg free.)
* Children with hives only after egg exposure can be vaccinated with any flu vaccine in any usual vaccination setting.

**List all of your child’s allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To help us determine if your child is eligible to receive vaccines from the Vaccines for Children Program, please check one of the boxes below.** Your child will receive flu vaccine whether or not they are eligible.

🖵 My child is enrolled in Medicaid (includes MassHealth and HMOs, etc., if enrolled through Medicaid)

🖵 My child does not have health insurance

🖵 My child is American Indian (Native American) or Alaska Native

🖵 My child has health insurance and is not American Indian (Native American) or Alaska Native