

If you would like your child to receive influenza vaccine at the School-Based Health Center, please complete.

Name _____ Date of Birth ____/____/____ Class _____

Circle One

Part 1: These questions will tell us if it is safe for your child to get influenza vaccine.		
1) Has your child had a reaction to an influenza vaccine before? If Yes , please describe here:	Yes	No
3) Does your child have an allergy to eggs? If Yes , please describe here:	Yes	No
4) Has your child ever had paralysis (inability to move all or part of the body) with Guillain- Barré Syndrome (GBS)? If Yes , please describe here:	Yes	No
Part 2: These questions will tell us if your child should get one or two doses of influenza vaccine.		
5a) Has your child ever received <i>seasonal</i> influenza vaccine before?	Yes	No
5b) If Yes : Did your child receive <i>seasonal</i> vaccine last year (2010-2011 influenza season)?	Yes	No
5c) If Yes : Was last year the <i>first</i> year your child ever received seasonal flu vaccine?	Yes	No
5d) If Yes : How many doses did your child receive <i>last year</i> ?	1 dose	2 doses
Part 3: These questions will tell us if your child should get an influenza shot or nasal spray.		
6) Does your child have any of the following: heart disease, lung disease, asthma, kidney disease, diabetes or anemia?	Yes	No
7) Does your child have cancer, leukemia, HIV/AIDS or other blood or immune system problems?	Yes	No
8) Has your child taken either steroids or anticancer drugs, or had cancer treatment with x-rays or radiation treatments in the past three months?	Yes	No
9) Has your child received a transfusion of blood products or been given a medication called immune (gamma) globulin in the past year?	Yes	No
10) Is your child regularly taking medications that contain aspirin?	Yes	No
11) Does your child have close contact with someone who is severely immunocompromised (such as someone in a bone marrow transplant unit of a hospital)?	Yes	No
12) Does your child have muscle or nerve disorders (such as seizure disorders or cerebral palsy) that has lead to breathing or swallowing problems?	Yes	No
13) Has your child received a nasal spray flu vaccine in the past four weeks?	Yes	No
14a) Has your child received measles, mumps and rubella (MMR) or varicella vaccine <i>in the past 28 days</i> ?	Yes	No
14b) If Yes , please circle which one(s).	MMR	Varicella

If your child is under 9 years of age, and has not received both seasonal influenza vaccines in the past, s/he may need to receive a second dose in 4 weeks.

By signing below, I am agreeing that I have read the Vaccine Information Statement and I want my child to receive the influenza vaccine at the School-Based Health Center.

Signature of Parent/Legal Guardian: _____ Date: ____/____/____

