Wicomico County Health Department

www.wicomicohealth.org

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Seasonal Live (Intranasal) Influenza Vaccination Screening and Consent Form

PARENTS/GUARDIANS: Please Read The Following Carefully Before Signing The Consent.

For your child to be eligible to receive the seasonal influenza vaccine at the school clinic, you must read and answer all questions, and sign this consent form. Please read the vaccine information statement we have provided to you. If this is the first time that a child under 9 years of age received the seasonal influenza vaccine, then s/he will need to receive a 2nd dose of the seasonal flu vaccine 4 weeks after the first dose. *If your child needs a second flu dose he/she may receive it by one of the following options: 1) through pediatrician's office, 2) at health department, 3) at a walk-in center, etc.*

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT**

School: _____Home Room Teacher: _____Grade: _____BIrthdate:_____

Last Name: _____ First Name: _____ Middle Name: _____ Age: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Emergency Contact Number: _____ Gender: M / F

Primary Language: _____ Hispanic: Yes / No Child's Pediatrician/Physician: _____

Race: _____White _____Black _____Asian _____American Indian _____Alaskan Native _____ Other: _____

Mother's Last Name: _____ Mother's First Name: _____

Father's Last Name: _____ Father's First Name: _____

OR, Guardian Last Name: _____ First Name: _____ Relationship:_____

If you want a Seasonal Influenza Vaccination given to your child, FILL OUT THE INFORMATION BELOW AND SIGN.

Please CHECK Yes or No to ALL questions below for the STUDENT	**YES**	**NO**
1. Has your child received a vaccine within the past 30 days? Name of Vaccine(s): Date Given:		
2. Does your child have asthma?		
3. Does your child have chronic heart diseases or breathing conditions?		
4. Does your child have diabetes or other metabolic diseases/disorders?		
5. Does your child have kidney diseases?		
6. Does your child have blood diseases?		
7. Has your child ever had a reaction to an injection? If yes, please describe:		
8. Is your child allergic to vaccine components, i.e. eggs, gentamicin, sulfate, MSG?		
9. Does your child have a cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorders?		
10. Has your child ever had Guillain-Barre syndrome?		
11. Is your child on long-term aspirin therapy?		
12. Does your child have a disease such as cancer, lupus, HIV?AIDS, or do they take a medication that lowers the body's resistance to infections?		
13. Does your child have close contact with anyone who is immunosuppressed?		
14. Please list any allergies:		

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