

# 2014- 2015 INFLUENZA VACCINE CONSENT AND SCREENING FORM

## Injectable (Flu Shot) or Nasal Spray Flu Vaccine

Information about the person 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: (    )			

**Insurance Information:** *Include the whole member ID number and any letters that are part of that number*

Name of Insurance Company:*	Member ID Number:*	Group ID Number: (if available)
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**If person getting vaccinated is not the subscriber, please complete the following:**

Subscriber's Name: (Last, First, MI)*			Subscriber's Date of Birth: * _____ Month    Day    Year			Sex: (Circle)* Male    Female	
Subscriber's Street Address: * (If different from address above)							
City:*		State:*	Zip: *	Phone: * (    )			
Patient Relationship to Subscriber: (Circle)*    Spouse    Child    Other							

**I GIVE CONSENT** for me / my child named at the top of this form to get vaccinated with this vaccine. I have read or had explained to me the 2014-2015 Vaccine Information Statement for the influenza vaccine and understand the risks and benefits.

**I give consent for my insurance company to be billed** if insurance information is entered above.

\_\_\_ Injectable only      \_\_\_ Nasal mist only      \_\_\_ Either injectable or nasal mist

X \_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of patient, parent or legal guardian)

**For children 18 years of age and younger:**

**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

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**For Clinic/Office Use Only:**

Date vax given:	Vax Type	Vax Manufacturer	Exp. Date/ Lot No	Dose	State Supplied	Preserv Free	Injection Route (Circle)	Injection Site (Circle)	Date On VIS	Date VIS given
					Yes No	Yes No	IM	R Arm    L Arm R Leg    L Leg	08/19/14	
	LAIV4	Medimmune		0.2 ml	Yes	N/A	Intranasal	N/A	08/19/14	

Clinic Site Name: Berkshire County Boards of Health Association

MDPH Provider PIN#: 11340

Clinic Address: 1 Fenn St, Suite 302, Pittsfield, MA 01201

Signature of Vaccine Administrator: \_\_\_\_\_ Date: \_\_\_\_\_

## Screening for *Injectable (Flu Shot) or Nasal Spray Vaccines*

Answering these questions will help us to know which type of flu vaccine you or 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. Did your child receive 1 or more doses between July 1, 2013 and June 30, 2014?  Yes  No
  2. If no, did your child receive 2 or more doses between July 1, 2010 and June 30, 2013?  Yes  No
  3. Has your child received flu vaccine this flu season (since July 1, 2014)?  **No** **If no, go to Section 2**  **Yes**  
 If yes, please tell us the number of doses and dates of vaccination.  1 dose  2 doses
- Dose 1:** Date received: month \_\_\_\_ day \_\_\_\_ 2014    **Dose 2:** Date received: month \_\_\_\_ day \_\_\_\_ 2014

### Section 2: Information to determine if your child should receive the 2014-2015 flu vaccine.

**A.** Please check YES or NO for each question. If you answer “YES” to one or more of the 4 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 okay for your child to get flu vaccine. If you answer “NO” to all 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. Do you or your child have a problem eating eggs?		
2. Do you or your child have an allergy to gentamicin, neomycin, polymixin or gelatin?		
3. Have you or your child ever had a serious reaction to a flu vaccine in the past?		
4. Have you or your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

**B.** There are 2 kinds of flu vaccine available. Your answers to the following questions will help us decide if you or your child is able to receive the nasal spray (live) vaccine.

	NO	YES
1. Have you or your child received any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month ____ day ____ year ____		
2. Do you or your child have asthma?		
3. Do you or your child have diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?		
3. 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?		
4. Do you or your child take aspirin or aspirin-containing medicine every day?		
5. Are you or your child receiving antiviral medications?		
6. Do you or your child have a weak immune system (from HIV, cancer, or medicines such as steroids or those used to treat cancer)?		
7. Are you or your child pregnant?		
8. Do you or 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)?		

#### List all you or your child’s allergies:

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**MIIS Policy:** Massachusetts law (M.G.L. c. 111, Section 24M) requires providers to report immunization information to computerized immunization registry known as the Massachusetts Immunization Information System (MIIS). The MIIS stores immunization records for you and your healthcare provider and can help prevent outbreaks of disease like measles and the flu. All information in the MIIS is kept secure and confidential. The MIIS allows information to be shared with health care providers, school nurses, local boards of health, and state agencies concerned with immunization. You have the right to object to the sharing of your immunization information across providers in the MIIS. For more information, please ask your healthcare provider, visit the MIIS website at [www.mass.gov/dph/miis](http://www.mass.gov/dph/miis) or contact the Massachusetts Immunization Program directly at 617-983-6800 or 888-658-2850.