NEW MEXICO DEPARTMENT OF HEALTH

SCHOOL INFLUENZA IMMUNIZATION CONSENT
FLU SHOT ONLY—no FluMist
Public Health Division SKIIP 2016-17

For school office use: Place sticker/stamp with school address here

If you would like the vaccine given at school, fill in this form completely and clearly, including complete insurance information and return by (date)_____ to the school nurse

Student's legal last name:_____ First name:_____ Middle name: _____

Mailing address:_____ City:_____ Zip: _____ Daytime phone: _____

Birth date: _____/_____/_____ Age:_____ Mother's maiden (birth) first and last name:_____
Month / day / year

Student ID#:_____ Teacher:_____ Grade:_____

Race: ☐ White ☐ American Indian/Native American/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Gender: ☐ Male ☐ Female

INSURANCE INFORMATION—Fill in appropriate category—REQUIRED

☐ Medicaid/ Centennial Care
Policy # / Member ID #_____
Centennial Care (Medicaid) #_____

☐ Private insurance
Member ID #_____ Group #_____
_____ _____
Policyholder name *Policyholder date of birth*

☐ No insurance / uninsured

Select your insurance

☐ Blue Cross Blue Shield
☐ Molina Healthcare
☐ Presbyterian Health Plan
☐ United Healthcare
☐ _____
Other insurance—write in company name

MEDICAL SCREENING QUESTIONS—REQUIRED

If you answer yes to any of questions 1-5 below, your child may not be able to be vaccinated at school.
This year, ONLY INJECTABLE flu vaccine will be available. The nurse will assess eligibility based on the answers to these questions.

	NO	YES
1) Does your child have a severe allergy (difficulty breathing, swollen face/lips, recurring vomiting) to eggs?	☐	☐
2) Does your child have a severe allergy (difficulty breathing, swollen face/lips, recurring vomiting) to gentamicin sulfate or hydrocortisone?	☐	☐
3) Has your child ever had a serious reaction to flu vaccine in the past, or developed Guillain-Barré syndrome (a temporary severe muscle weakness)?	☐	☐
4) Does your child have hemophilia (a severe bleeding disorder)?	☐	☐
5) Has your child received a flu vaccine this school year—since August 2016? If so, date given:_____	☐	☐
6) Does child have allergy or sensitivity to latex? (If so, latex gloves will not be used)	☐	☐
Question 7 helps to determine if your child (less than 9 years old) will need one or two doses of flu vaccine.	NO	YES
7) Has your child received at least two doses of the flu vaccine before July 2016?	☐	☐

CONSENT FOR CHILD'S VACCINATION IN SCHOOL—REQUIRED

I have read or had explained to me information in the current Injectable Influenza Vaccine Information Statement. I understand the benefits and risks of the influenza vaccine and consent to the above-named child receiving influenza vaccine at school. If my child is less than 9 years old and it is determined that a 2nd dose is needed, I also consent for a 2nd dose of vaccine to be given if offered through the school. Unless I sign a statement signifying otherwise, I consent to immunization information being entered into the New Mexico Statewide Immunization Information System (NMSIIS) and being released to other medical care providers to avoid unnecessary vaccination or to ascertain immunization status. The Revised NMDOH Privacy Policy is available at http://nmhealth.org/help/privacy/ and will be provided to all students when they receive an immunization.
I will contact the school nurse to withdraw this consent if this child is immunized before the date of the school clinic.

Signature of parent/legal guardian_____Date_____

Print name of parent/legal guardian *(print clearly in all caps)* _____

For clinic use (this section must be completed by the medical provider) **Current VIS date: 8-7-2015**

Dose #1 VACCINE: ☐IIV Flucelvax Seqirus ☐Other_____ Lot #_____

Site of administration: ☐R Deltoid ☐L Deltoid ☐ Other_____ Exp. date _____

_____ Signature:_____ _____
Date vaccinated *Name and title of vaccine administrator* *Preceptor name and credentials*

Dose #2 VACCINE: ☐IIV Flucelvax Seqirus ☐Other_____ Lot #_____

Site of administration: ☐R Deltoid ☐L Deltoid ☐ Other_____ Exp. date _____

_____ Signature:_____ _____
Date vaccinated *Name and title of vaccine administrator* *Preceptor name and credentials*

Required: Date VIS given to patient (stamp or print)

Dose #1
VFC PIN #_____
Date NMSIIS data entry:_____

Dose #2
VFC PIN #_____
Date NMSIIS data entry:_____