


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

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

Student's legal last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle name: \_\_\_\_\_  
 Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Mother's maiden (birth) first and last name: \_\_\_\_\_  
Month / day / year  
 Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: **NM** Zip: \_\_\_\_\_ Daytime phone: \_\_\_\_\_  
Apt. # / Unit  
 Student ID#: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Gender:  Male  Female  
 Ethnicity:  Hispanic  Non-Hispanic  
 Race:  White  Black/African American  American Indian/Native American/Alaska Native  Native Hawaiian/Pacific Islander  Asian  Other

**INSURANCE INFORMATION—Fill in appropriate category—REQUIRED**

<input type="checkbox"/> Medicaid/ Centennial Care	Policy # / Member ID # _____ Group # _____ Centennial Care (Medicaid) # _____		<input type="checkbox"/> Blue Cross Blue Shield
<input type="checkbox"/> Private insurance	Member ID # _____ Group # _____ Policyholder name _____ Policyholder date of birth _____		<input type="checkbox"/> Molina Healthcare
<input type="checkbox"/> No insurance / uninsured			<input type="checkbox"/> Presbyterian Health Plan <input type="checkbox"/> United Healthcare <input type="checkbox"/> _____ <small>Other insurance—write in company name</small>

**MEDICAL SCREENING QUESTIONS—REQUIRED**

If you answer yes to any of questions 1-4 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? .....	<input type="checkbox"/>	<input type="checkbox"/>
2) Has your child ever had a serious reaction to flu vaccine in the past, or developed Guillain-Barré syndrome (a temporary severe muscle weakness)? .....	<input type="checkbox"/>	<input type="checkbox"/>
3) Does your child have hemophilia (a severe bleeding disorder)? .....	<input type="checkbox"/>	<input type="checkbox"/>
4) Has your child received a flu vaccine this school year—since August 2017? If so, date given: _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Does child have allergy or sensitivity to latex? (If so, latex gloves will not be used).....	<input type="checkbox"/>	<input type="checkbox"/>

*Question 6 helps to determine if your child (less than 9 years old) will need one or two doses of flu vaccine.*

	NO	YES
6) Has your child received at least two doses of the flu vaccine before July 2017? .....	<input type="checkbox"/>	<input type="checkbox"/>

**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 2<sup>nd</sup> dose is needed, I also consent for a 2<sup>nd</sup> 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	Required: Date VIS given to patient (stamp or print)
Dose #1 VACCINE: <input type="checkbox"/> IIV Flucelvax Seqirus <input type="checkbox"/> Other _____	Lot # _____		
Site of administration: <input type="checkbox"/> R Deltoid <input type="checkbox"/> L Deltoid <input type="checkbox"/> Other _____	Exp. date _____		
_____ <small>Date vaccinated</small>	_____ <small>Signature: Name and title of vaccine administrator</small>	_____ <small>Preceptor name and credentials</small>	Dose #1 VFC PIN # _____
Dose #2 VACCINE: <input type="checkbox"/> IIV Flucelvax Seqirus <input type="checkbox"/> Other _____	Lot # _____		Date NMSIIS data entry: _____
Site of administration: <input type="checkbox"/> R Deltoid <input type="checkbox"/> L Deltoid <input type="checkbox"/> Other _____	Exp. date _____		
_____ <small>Date vaccinated</small>	_____ <small>Signature: Name and title of vaccine administrator</small>	_____ <small>Preceptor name and credentials</small>	Dose #2 VFC PIN # _____ Date NMSIIS data entry: _____