NEW MEXICO DEPARTMENT OF HEALTH

School Influenza Immunization Consent
Flu vaccine — SKIIP 2019-20

Please fill in form completely–required fields are marked with an asterisk (*)

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

If you would like your child to be given a flu vaccine at school, fill in this form completely and print in all capitals, including complete insurance information and return to the school nurse by (date)_____

***Student's legal last name:**	***Student's legal first name:**		**Middle name:**
***Student's date of birth:** (month/day/year)	**Age**	***Mother's maiden (birth) name:**	***Mother's first name:**
***Mailing address:**	***City:**	**State** NM	***Zip:**
***Phone #:**	**Student ID#:**	**Teacher name**	**Grade**

***Sex:** ☐ Female ☐ Male

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

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

INSURANCE INFORMATION – Please mark appropriate category — REQUIRED

☐ **Medicaid—select your Centennial Care Plan:** ☐ Blue Cross Blue Shield ☐ Presbyterian ☐ Western Sky Community Care
☐ Other:_____ Centennial Care/Medicaid card ID#: _____Insurance member ID#:_____Group #:_____

☐ **No insurance**

☐ **Private/commercial insurance** — Please print name of insurance: _____
Health insurance member ID/ Subscriber #: _____Group #:_____

MEDICAL SCREENING QUESTIONS — REQUIRED

For parents/guardians: If you answer yes to any of questions 1-4 below, your child may not be able to be vaccinated at school. The nurse will assess eligibility based on the answers.	**Yes**	**No**	**I don't know**
1) Does your child have a **severe** allergy to eggs (difficulty breathing, swollen face/lips, recurring vomiting)?			
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)?			
3) Does your child have hemophilia (a severe bleeding disorder)?			
4) Does your child have an allergy to latex? (If so, latex gloves will not be used)			
5) Has your child received a flu vaccine this school year—since August 2019? If so, date given:_____			
6) Has your child received at least two doses of the flu vaccine before July 2019?			
Questions 7-11 below will help to determine if your child can receive FluMist.			
7) Has your child received any vaccines within the past 30 days? Please list_____; dates given_____			
8) Has your child had an asthma attack, a wheezing episode, or taken asthma medicine within the last 12 months?			
9) Does your child have: Diabetes, diseases of the heart, liver, kidneys or lungs, seizures, blood disorder, anemia, neuromuscular disease, or cerebral palsey?			
10) Does your child have close or direct contact with someone who is in a protected environment for an extremely weakened immune system (for example, bone marrow transplant unit)?			
11) Is your child pregnant?			

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. 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:** _____

FOR CLINIC USE ONLY — REQUIRED

Vaccine (quadrivalent)	**Vaccine admin. date**	**Lot #**	**Site/route**	**Expiration date**
☐ Flucelvax-Seqirus ☐ FluLaval-GSK ☐ FluMist-AstraZeneca ☐ Fluzone-Sanofi ☐ Other_____			☐ L deltoid ☐ R deltoid ☐ other_____	

Print vaccinator name & title	Vaccinator signature	Preceptor name & credentials

Date VIS given to parent/ patient–required* (stamp or print)	**Current VIS date** **8-15-2019**	**VFC PIN #:** (if applicable)	**Notes:**

Date NMSIIS data entry:	Date TransactRx data entry:	NMSIIS ID #:

DIRECT NMSIIS ENTRY OF VACCINES ADMINSTERED IS REQUIRED. FOR NM DOH OUTREACH: Data must be entered into TransactRx within 30 days of the date of service. If unable to enter data within 30 days, please contact your Director of Nursing Services. This form was designed for NM DOH public health offices and program use only. NM DOH is not responsible for data entry or vaccine administration from outside health entities and expressly disclaims liability for any associated errors as a result from utilization of this form.