ANCHORAGE SCHOOL DISTRICT
HEALTHCARE SERVICES
SEASONAL INFLUENZA VACCINE CONSENT FORM
FLU SHOT 2017-18

Child's Name :----------PLEASE PRINT CLEARLY----------			*Date of Birth (mm-dd-yyyy)* - -
Last:	First:	M.I.	
Street Address:			Gender ☐ Male ☐Female
City	State	Zip Code	Telephone Number ( )
Race (Check One) ☐White ☐American Indian ☐Black or African American ☐Asian ☐Alaska native ☐Other ☐Native Hawaiian or Other Pacific Islander ☐Multiracial ☐Unknown			Ethnicity (check one) ☐Hispanic or Latino ☐Non-Hispanic or Latino
Mother's Maiden Name (Last, First) (VactrAK requirement)	Name of School:		Grade:
Name of Parent or Guardian Responsible for Child if under 18: (Last, First Middle)			Relationship to child:

***__**This section must be completed:**__ VFC Eligibility

☐ Medicaid (Medicaid eligible or Medicaid enrolled) ☐ Native American or Alaskan Native

☐ No Health Insurance (VFC Uninsured) ☐ Insured (State Vaccine AVAP)

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 in school.	**YES**	**NO**
1. Has your child had allergic reaction to eggs?		
2. Has your child had an allergic reaction to the flu vaccine or any component of the vaccine in the past?		
3. Does your child currently have moderate to severe illness with or without fever?		
4. Has your child ever had Guillain-Barré Syndrome ((a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

Consent for Child's Vaccination:

☐ ***Yes**, I give my permission for the child named above to be vaccinated with the **Flu Injection** (inactivated vaccine). I have read the Vaccine Information Statement for influenza vaccine and understand this consent will be valid for the number of doses recommended for my child's age and immunization history.*

☐ ***Yes**, I give authorization for the nurse at Anchorage School District to review & enter immunization records within the VACTRAK system managed by the Epidemiology Section of the Alaska Department of Health and Social Services for my above named child.*

(If this consent form is not signed, then your child will not be vaccinated)

Parent/Guardian Name (PRINT) _____

Parent/Guardian Signature_____ **Date signed** _____

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Vaccination Record **FOR ADMINISTRATIVE USE ONLY**

Before vaccinating, review form for child's **name**, contraindications, DOB, and **consent** to vaccinate (Make sure **YES** consent box is marked and signed)

Make sure VFC eligibility is completed.

First Dose—District Use Only

Vaccine	Date Dose Administered	Manufacturer, Lot#, Expiration date, VIS Date	Vaccinator's Signature	Anatomical Site & Dose
Influenza		Manufacturer: Lot #: Expiration Date: VIS Date:		☐ **IM**** RD ☐ **IM**** LD ☐ **DOSE FULL**

Second Dose

Vaccine	Date Dose Administered	Manufacturer, Lot#, Expiration date, VIS Date	Vaccinator's Signature	Anatomical Site & Dose
Influenza		Manufacturer: Lot #: Expiration Date: VIS Date:		☐ **IM**** RD ☐ **IM**** LD ☐ **DOSE FULL**

****FLU INJECTION** RD- Right Deltoid LD- Left Deltoid

Vaccines must be entered in VactrAK within 14 days and Student Information System (SIS- Zangle/Q))