Chester County Health Department School Influenza Vaccination Program

Dear Parent,

The Chester County Health Department will be offering the influenza vaccine to school students. The goal of this program is to minimize absenteeism in the school and the community from influenza-related illness. Influenza is a very serious disease that strikes even healthy children. Health authorities are now recommending that all children, ages 6 months to 18 years old, be vaccinated against influenza. There is no charge for the vaccine.

The vaccine will be administered by experienced Registered Nurses. The nurses will be offering both the influenza nasal spray and the influenza shot at the school. Please complete the questionnaire on the back, which will help the nurse determine what type of flu vaccine your child will receive. If a question is not clear, please call 610-344-6252.

In order to participate in this program, please fill out this form completely for your child and return it to your child's school nurse.

CHILD'S INFORMATION:

______________________________ ________________________ ________
Last Name First Name **Grade**

____ ________
Address Apt/Suite

______ ______/______/______
Age **Month** **Day** **Year**
Date of Birth

________________________________ ______ ________ (______) ______-_______
City State Zip Area Code & Phone Number

Parent email address:____

PLEASE CIRCLE

Gender: Male Female

Race: Asian or Pacific Islander Asian Indian
African American Other (specify): ________________
White

Ethnicity: Non Hispanic Hispanic Unknown

Health Plan: Medicare Medicaid Unknown
No Insurance CHIP Private Insurance (Name________________________)

PARENT or LEGAL GUARDIAN CONSENT:

I give permission for my child to receive a 2013/14 influenza vaccine at the school at no charge. I understand vaccine information may be shared with my child's primary care provider or school. I understand I have the right to revoke this consent anytime before the vaccine is given. I understand I have the right to review this information. I received a copy of the Vaccine Information Statement.

Parent/Guardian (please print): Last ________________________ First ________________________

Parent/Guardian Signature: ____________________________________ Date____________________

Relationship to child: (please circle) Mother Father Legal Guardian

Please turn over →

Screening Questionnaire for Influenza Vaccination

Please circle

1.	Does your child have an allergy to eggs?	Yes	No
2.	Does your child have an allergy to Gentamycin, latex, gelatin or thimerosal?	Yes	No
3.	Has your child ever had a serious reaction to an influenza vaccine?	Yes	No
4.	Has your child ever had Guillain-Barré Syndrome?	Yes	No
5.	Does your child have a seizure disorder?	Yes	No
6.	Does your child have asthma? If the answer is no, skip to question 9.	Yes	No
7.	If your child has asthma, has it been longer than 12 months since wheezing or taking asthma medication?	Yes	No
8.	If you answered yes to question 7: A child who has not had wheezing or taken asthma medication for more than 12 months may receive Flumist. There may be an increased chance of wheezing after receiving Flumist. **Please initial if you would like your child to receive Flumist**. → → →		
9.	Has your child ever had a health problem with lung disease, heart disease, kidney disease, metabolic disease (e.g. diabetes), a blood disorder or is currently receiving aspirin therapy?	Yes	No
10.	Does your child have cancer, leukemia, AIDS or any other immune system problem?	Yes	No
11.	Has your child taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments (does not include x-rays) in the past 3 months?	Yes	No
12.	Has the child received a transfusion of blood or blood products or been given a medicine called immune (gamma) globulin in the past year?	Yes	No
13.	Is your child/teen pregnant or is there a chance she could become pregnant during the next month?	Yes	No
14.	**In the past four (4) weeks** has your child received a Measles Mumps Rubella (MMR), Varicella (chickenpox), Yellow Fever or Flu Mist vaccine?	Yes	No
15.	Does your child have close contact with anyone who has a weakened immune system who is in the hospital **in a protective environment** (e.g. an individual who has had a bone marrow transplant)? Please describe: ____	Yes	No

FOR CLINIC/OFFICE USE ONLY	
Is child sick today? Yes or No	
Date Vaccine Administered: ______/______/_________	Lot Number:
Clinic Site:	Vaccine Manufacturer: Sanofi Pasteur GSK MedImmune
Site of Injection: RD, IM LD, IM IN	Expiration: ______/______/_________
Signature of Vaccine Administrator:	VIS Dates: LAIV 7/26/13 IIV 7/26/13