Anchorage School District

Healthcare Services Department

SEASONAL INFLUENZA VACCINE CONSENT FORM

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)

STREET ADDRESS	GENDER ☐ Male ☐ Female

CITY	STATE	ZIPCODE	TELEPHONE ( )

RACE	ETHNICITY
☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black or African American ☐ Multiracial ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Unknown ☐ White	☐ Hispanic or Latino ☐ Non-Hispanic or Latino

MOTHER'S MAIDEN NAME (LAST, FIRST)	NAME OF SCHOOL	GRADE

NAME OF PARENT / GUARDIAN	RELATIONSHIP TO CHILD

FLU VACCINE ELIGIBILITY

One box from this section must be selected to be eligible to receive a free flu vaccine.

ASD STUDENT

- ☐ **Medicaid or Denali Kid Care** (VFC Medicaid Eligible)
- ☐ **No medical insurance** (VFC Uninsured)
- ☐ **Native American or Alaska Native**
- ☐ **Insurance that covers vaccines** (State Vaccine AVAP)
- ☐ **Insurance that does not cover vaccines** (VFC Underinsured)

ASD EMPLOYEE -or- DEPENDENTS

- ☐ **Insurance that covers vaccines** (State Vaccine AVAP)

*ASD employees must be able to provide proof of health insurance, if requested. Your medical insurance will not be billed for this vaccine.

Please answer the four questions below. Your answers will be used to determine if it is safe for you to receive the flu vaccine. If you answer "YES" to any of these questions, you will not be able to receive a flu vaccine from ASD unless you have a medical provider's note stating it is safe for you to be vaccinated.

	YES	NO
Have you ever had a reaction to the flu shot before?		
Do you have an allergy to chicken or egg products?		
Have you been diagnosed with Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?		
Do you currently have any fever or infection other than the common cold?		

CONSENT FOR VACCINATION

The most current Vaccine Information Sheet (VIS) has been made available for me to read. I understand their contents and hereby consent to receive (or for my child to receive) the flu vaccine. I understand this consent will be valid for the number of doses recommended. **YES**, I give authorization for the nurse to review and enter the administration of this vaccine into VacTrAK, a vaccination record system managed by the State of Alaska, Department of Health and Social Services, Section of Epidemiology.

PRINTED NAME (Parent/guardian if person is under 18 years old)	

SIGNATURE	DATE SIGNED

If this consent is not signed, the flu vaccine will not be administered.

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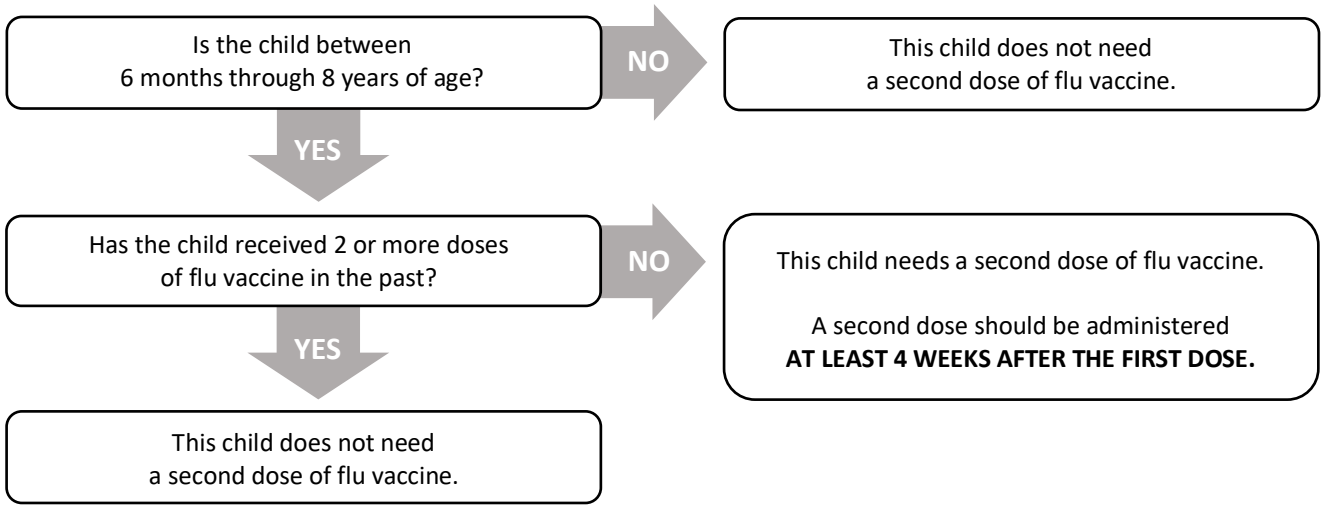
VACCINATION RECORD – FOR NURSE USE ONLY

FIRST DOSE				
VACCINE TYPE	DATE VACCINE ADMINISTERED	ROUTE AND ANATOMICAL SITE (PLEASE CIRCLE)	MANUFACTURER, LOT NUMBER, EXPIRATION DATE, AND VIS DATE	VACCINATOR'S PRINTED NAME AND SIGNATURE
Influenza, injectable, quadrivalent, preservative free		IM – Right deltoid IM – Left deltoid IM – Right anterolateral thigh IM – Left anterolateral thigh		

SHOULD THIS STUDENT RECEIVE A SECOND DOSE?



SECOND DOSE				
VACCINE TYPE	DATE VACCINE ADMINISTERED	ROUTE AND ANATOMICAL SITE (PLEASE CIRCLE)	MANUFACTURER, LOT NUMBER, EXPIRATION DATE, AND VIS DATE	VACCINATOR'S PRINTED NAME AND SIGNATURE
Influenza, injectable, quadrivalent, preservative free		IM – Right deltoid IM – Left deltoid IM – Right anterolateral thigh IM – Left anterolateral thigh		