School-Based Clinic: Seasonal Influenza ("Flu") Vaccination Record & Consent

DO NOT RETURN THIS FORM IF YOU DECLINE VACCINATION

PARENT/LEGAL GUARDIAN INFORMATION (IF MINOR):
Full Name: _____ Daytime/Cell Phone Number: _____

VACCINE RECIPIENT INFORMATION:
Last Name: _____**First Name**: _____ **M.I**.___
DOB: _____/_____/_____ **Age:** _____
Mailing Address:
Street Address: _____Town/City: _____State: _____Zip: _____
Physical Address:
Street Address: _____Town/City: _____State: _____Zip: _____
Email Address (parent/guardian email if minor): _____
Cell Phone Number (parent/guardian number if minor): _____

Gender: ☐ Female ☐ Male ☐ Non-Binary ☐ Unknown/Not Reported
Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Unknown/Not Reported
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Other Race ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown/Not Reported
Complete for Vaccine Recipient: Does the person being vaccinated currently have Medicaid, Well Sense, NH Healthy Families or AmeriHealth Caritas? ☐ Yes ☐ No

SCREENING QUESTIONS:

Please answer the questions below for the person who is receiving the vaccine to determine if there is any reason they should not get the influenza vaccine. **If you answer "yes" to any of the questions, please contact your medical provider to discuss other ways to receive the vaccine.** **If vaccine recipient is sick or unwell on the day of vaccination, they will not be vaccinated.**	**Yes**	**No**
1. Have you ever had a severe allergic reaction (like anaphylaxis) to eggs or any component* of the influenza vaccine? *More information on vaccine ingredients (components) is available from the FDA at: https://www.fda.gov/vaccines-blood-biologics/vaccines/influenza-virus-vaccine-quadrivalent-types-and-types-b	☐	☐
2. Have you ever had a severe allergic reaction (like anaphylaxis) to a previous dose of any influenza vaccine?	☐	☐
3. Have you ever had Guillain-Barre syndrome (GBS) (an autoimmune neurological condition that results in sudden muscle weakness) that developed within 6 weeks after receiving an influenza vaccine?	☐	☐

CONSENT AND NOTICES:
A copy of your/your child's vaccine record will be provided to you for your records. We recommend that you share a copy of this record with your/your child's healthcare provider. You may also choose to Opt-in to the NHIIS so that your provider may access the record electronically. Per NH RSA 141-C:20-f sharing your/your child's vaccine information with the NHIIS is voluntary and you are provided an opportunity to Opt-In (to share information) or Opt-Out (to not share information) prior to vaccination. No information will be shared with the NHIIS unless you have provided explicit consent to share your/your child's vaccine information.

Recipient Last Name: _____ First Name: _____ M.I. _____

☐ **I have been provided and reviewed information on the NH Immunization Information System (NHIIS).**

NHIIS Consent: I choose to (check one):

☐ **Opt-In (share information)** I am consenting to share my/my child's vaccine information with the NHIIS.

Signature:_____

☐ **Opt-Out (do not share information)**

Immunization Consent: By signing below, I am acknowledging that I have received and reviewed the information provided, I have had any questions satisfactorily answered, and I understand the risk and benefits of receiving the influenza vaccine. By signing below, I also confirm that the information entered on this form is accurate and I GIVE CONSENT for the person named above (self or minor child) to be vaccinated with an age-appropriate influenza vaccine.

☐ **I have reviewed the Influenza Vaccine Information Statement at:**
https://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf

Printed Name of Person Receiving Vaccine/Parent or Legal Guardian (if Minor):	
Signature of Person Receiving Vaccine/Parent or Legal Guardian (if Minor):	**Date:**

VACCINE RECIPIENT/PARENT/GUARDIAN - STOP HERE (ADMINISTRATIVE USE ONLY)

VACCINE ADMINISTRATOR MUST COMPLETE THE FOLLOWING SECTIONS:

Clinic/School Name:			
BEFORE vaccinating, complete the following (check to confirm done): ☐ I have verified that the attached consent form has been signed by the vaccine recipient or parent/guardian (if minor) ☐ I have asked the recipient if they are feeling sick or unwell today (if vaccine recipient is sick, do NOT give vaccine) ☐ I have reviewed this form including the medical screening questions to identify potential vaccinate contraindications or precautions			☐ Recipient NOT vaccinated **Reason:** ☐ Absent or did NOT attend clinic ☐ Refused the vaccine ☐ Incomplete consent form ☐ Other_____
If vaccine recipient is sick or answers "yes" to any of the screening questions, STOP! Vaccine may not be appropriate, or additional information may need to be collected from the parent/guardian.			
Administration Date:	**Administration Time:**		**Wait Time:** ☐ 15 min ☐ 30 min
Vaccine Name/Manufacturer:	Lot Number:		Expiration Date:
Route/Body Site:	VIS Publication Date:		VIS Given Date:
Provider Name & Address:			
Name and Title of Vaccine Administrator:			
Signature of Vaccine Administrator:			
☐ NHIIS Opt In, Explicit Written Consent obtained	Date Entered into NHIIS:	Entered into NHIIS By:	☐ NHIIS Opt Out, DO NOT Enter into NHIIS (record maintained by RPHN)
Needs Review: Yes ☐ No ☐	After vaccination this form was reviewed by:		Review Completed Date (if applicable):