Anchorage School District
Healthcare Services

Influenza Vaccine Consent

LAST NAME	FIRST NAME	MI	DATE OF BIRTH
STREET ADDRESS			GENDER
CITY	STATE	ZIP CODE	PHONE

RACE
- ☐ Alaska NativeAmerican Indian ▢ Asian ▢ Black/African American ▢ Multiracial
- ☐ Native Hawaiian/Pacific Islander ▢ Unknown ▢ White ▢ Other: ___________________

ETHNICITY
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino

MOTHER'S MAIDEN NAME (Last, First)	SCHOOL *(if ASD student)*	GRADE *(if ASD student)*

FLU VACCINE ELIGIBILITY

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

CHILDREN (6 months through 18 years of age)
- ☐ Medicaid or Denali Kid Care *(VFC Medicaid Eligible)*
- ☐ No medical insurance *(VFC Uninsured)*
- ☐ Native American or Alaska Native *(VFC American Indian/Alaska Native)*
- ☐ Insured *(State Vaccine AVAP)*
- ☐ Underinsured *(State Vaccine AVAP)*

ADULTS (19 years of age and older)
- ☐ Insurance that covers vaccines *(State Vaccine AVAP)*
- ☐ Other *(Private Vaccine)*

HEALTH SCREEN QUESTIONNAIRE

Please answer the questions below. 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.

Question	Yes	No
Have you ever had a reaction to the flu shot before?	▢ Yes	▢ No
Do you have any allergies, including allergies to chicken or egg products?	▢ Yes	▢ No
Have you been diagnosed with Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?	▢ Yes	▢ No
Do you currently have any fever or infection other than the common cold?	▢ Yes	▢ No

CONSENT FOR VACCINATION

The most current Vaccine Information Sheet (VIS) has been made available for me to read. I understand its 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 into VacTrAK, a vaccination record system managed by the State of Alaska, Department of Health and Social Services, Section of Epidemiology.

I hereby agree and give consent to allow the Anchorage School District to give me (or my child) the flu vaccine. I understand that any vaccine may cause some side effects. The most commonly reported side effects may include soreness at the injection site and "mild" flu-like symptoms. Rare side effects may include allergic reaction and Guillain-Barre syndrome. I understand the benefits and risks of the vaccine and I consent to the administration of the vaccine. I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering health care professional. Furthermore, I hereby release and forever discharge for myself, my heirs, executors, administrators, and assignees, the Anchorage School District and its employees, volunteers, agents and representatives from any and all claims, demands, actions, and causes of action, which may result from receiving the flu vaccine. I will communicate the information provided to me today about my (or my child's) vaccination to my primary care provider.

PARENT/GUARDIAN (if person is under 18 years old)	RELATIONSHIP TO MINOR
SIGNATURE	DATE SIGNED

CONSENT MUST BE SIGNED TO RECEIVE THE VACCINE

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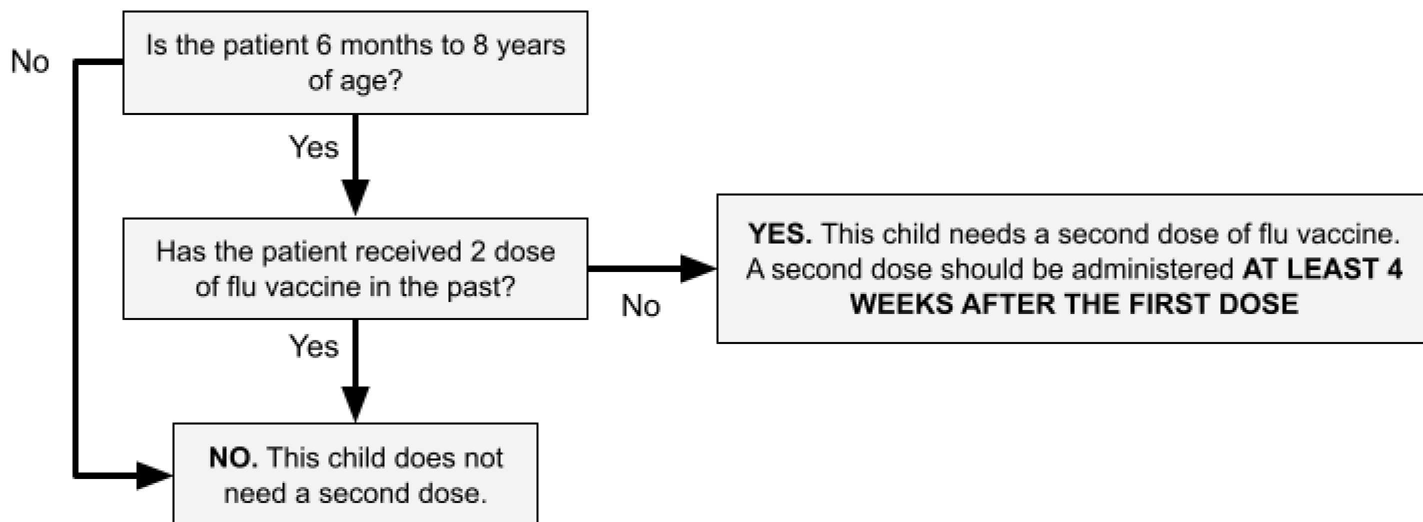
VACCINATION RECORD – FOR NURSE USE ONLY				
Vaccine	**Date Administered**	**Route and Site**	**Lot Number / Exp Date / VIS Date**	**Vaccinator Name Signature / Title**
Influenza, injectable, quadrivalent, preservative free		☐ IM - Right Deltoid ☐ IM - Left Deltoid ☐ IM - Right anterolateral thigh ☐ IM - Left anterolateral thigh	Lot#: Exp Date: VIS Date:	

SHOULD THIS PATIENT RECEIVE A SECOND DOSE?



For children 8 years of age who need two doses of vaccine, both doses should be administered even if the child turns 9 years of age between receipt of dose 1 and dose 2.

SECOND DOSE – FOR NURSE USE ONLY				
Vaccine	**Date Administered**	**Route and Site**	**Lot Number / Exp Date / VIS Date**	**Vaccinator Name and Signature**
Influenza, injectable, quadrivalent, preservative free		☐ IM - Right Deltoid ☐ IM - Left Deltoid ☐ IM - Right anterolateral thigh ☐ IM - Left anterolateral thigh	Lot#: Exp Date: VIS Date:	