

2010-2011 School-Located Influenza Vaccination Form



Student's Last Name _____ First Name _____ MI _____

Student's Date of Birth (MM / DD / YYYY) ____ / ____ / ____ Age _____ Sex: Male Female

Student's Street Address _____ Apartment # _____

City _____ State _____ ZIP Code _____ Home Phone (____) ____ - _____

Cell phone (____) ____ - _____ Social Security Number _____

Ethnicity: Hispanic Non-Hispanic **Race:** Amer. Indian / AK Native Asian Black/African Amer. Native HI/Pacific Island White Other

Questions about the student to be vaccinated – Please answer all questions	Don't		
	Yes	No	Know
Is the student sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the student have an allergy to eggs, or to any other component of the influenza vaccine (including polymyxin, neomycin, gentamicin, and gelatin)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the student ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the student ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the student have ongoing health problems (like diabetes, autoimmune, neurologic, heart or lung problems, asthma) or take aspirin regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If the student is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the student have a weak immune system or close contact with someone whose immune system is severely weak?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the student pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the student received other live-virus vaccines (MMR, chickenpox) in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the student receive H1N1 vaccine in late 2009 or early 2010? Please attach records if possible.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the student ever received seasonal flu vaccine? Please attach records if possible.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was last year the first time the student received seasonal flu vaccine? How many doses? ____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Insurance Information: CareSource Molina Medicaid Other _____

Information from insurance card: Policy number _____ Phone number _____

Claims address on insurance card _____

The student does not have health insurance.

I am unable to pay for services rendered (sign here for hardship waiver.) _____

Consent: *I have read and understand the information about influenza and influenza vaccine. I have had a chance to ask questions. I understand the benefits and risks of influenza vaccination and ask that the vaccine be given to me or the person named above for whom I am authorized to sign. I give consent for my child named at the top of this form to get vaccinated. I also understand that any care received outside Columbus Public Health (e.g., referred care) will not be paid for by Columbus Public Health. I authorize the release of medical information necessary to process this claim for billing. I understand I may be billed for my co-pay and for any charges not covered by insurance or grants, unless I sign the hardship waive above.*

I understand that the Privacy Notice of Columbus Public Health is available on the internet at: publichealth.columbus.gov/Asset/iu_files/HIPAA_Privacy_Notice.pdf. I can also have it mailed to me by calling 614-645-2738.

Patient or Guardian Signature: _____ **Date:** _____

Do not write in the gray area—Health Department nurses will decide which flu vaccine a child gets, based on availability and eligibility.

Staff Screener Signature _____	Office Assessment(99211/15) _____	NG encounter# _____
Manufacturer _____	Flumist(90660/10): <input type="checkbox"/> Nasal	TC ____ TP ____
Lot Number _____	Injectable(90658/10): <input type="checkbox"/> Left Deltoid IM <input type="checkbox"/> Right Deltoid IM	
Expiration Date _____	Nurse Signature _____	Date _____