Annual Influenza Vaccine Consent Form-FLU SHOT (Children's Form)

Section 1: Information about Child to Receive Vaccine (please print)

STUDENT'S NAME (Last)	(First)	(M.I.)	**STUDENT'S DATE OF BIRTH** **month_____ day_____ year _____**	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**STUDENT'S AGE**	**STUDENT'S GENDER** **M / F**
ADDRESS			**PARENT/GUARDIAN DAYTIME PHONE NUMBER:**	
CITY	**STATE**	**ZIP**		
STUDENT'S DOCTOR'S NAME (Last, First)				

SCHOOL NAME	**HOMEROOM TEACHER'S NAME**	**GRADE**
Health Insurance Name	**Insurance ID#**	**Policy Holder's Name**
Insurance BIN #	**Insurance Group#**	**Policy Holder's DOB**

Section 2: Screening for Vaccine Eligibility

Was your child ever vaccinated with the seasonal influenza vaccine? YES NO

The following questions will help us to know if your child can get the seasonal influenza vaccine. If you answer "NO" to all three of the following questions, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following three questions, your child may be able to get the seasonal influenza vaccine, but discuss with a healthcare professional before.

	YES	NO
1. Does your child have a serious allergy to eggs?		
2. Has your child ever had a serious reaction to a previous dose of flu vaccine?		
3. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
4. If your child is sick on the day of the clinic, they cannot get the vaccine.		

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:

I have read or had explained to me the Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits. **Please have your child bring this consent form back to school upon completion.**

I GIVE CONSENT to Wayland Village Pharmacy and its staff for my child named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then your child will not be vaccinated)

Signature of Parent/Legal Guardian _____

Date: month_____day_____year_____

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number/Expiration	Name and Title of Vaccine Administrator
Influenza (Flucelvax)	IM Deltoid □ L / □ R	10/14/2026	Seqirus	□ 418649 / 06/11/2027 (Single-dose)	□ Joseph Romph Pharmacist □ Andy Mai Pharmacist □ Chris Birman Pharmacist