

2010-2011 Flu Vaccination Consent Form – Grove Public Schools

Teacher _____ **School Site** _____ **Grade** _____

Printed name of Child: _____

Date of Birth: _____ Age: _____

Printed Name of Parent/Guardian: _____

Please circle **Yes or No** to the questions below:

Yes No 1. Has your child received a vaccine within the last 30 days?

Yes No 2. Has your child received a flu vaccination before?

Yes No 3. Is your child allergic to eggs, egg proteins, gentamicin, gelatin, or arginine?

Yes No 4. Has your child ever had a life threatening reaction to any Influenza vaccine?

Yes No 5. Is your child currently receiving aspirin or aspirin-containing therapy?

Yes No 6. Does your child have asthma, recurrent or active wheezing?

Yes No 7. Has your child ever been diagnosed with Guillain-Barre syndrome?

Yes No 8. Does your child have any disease (cancer, lupus, HIV/AIDS) or take any medications (steroids or chemotherapy) that lower the body's resistance to disease?

Yes No 9. Does your child have any long-term health problems such as:

Heart disease

Lung disease

Kidney or Liver disease

Metabolic disease (such as diabetes)

Seizure disorder

Yes No 10. Is your child in close contact with someone whose immune system is so weak they require a protected environment?(ex: bone marrow transplant unit)

List any allergies or medical alerts: _____

Additional notes: _____

I request that the influenza vaccination be given to my child.

Signature of person authorized to make this request

Date