2018-19 STUDENT INFLUENZA VACCINATION CONSENT FORM
INACTIVATED INFLUENZA (IIV) ONLY

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

[redacted]

Name: _____ (Last, First, MI)

Birth Date: ___/___/___ Age: _____ Gender: ☐ M ☐ F

If minor – parent/guardian's name: _____ (Last, First, MI)

Parent/Guardian's Date of Birth: ___/___/___ Parent's SSN: _____ (optional)

Address: _____ City/State: _____ ZIP: _____

Grade: _____ Home Room Teacher: _____ School: _____

IMPORTANT Parent/Guardian Phone #: Home: _____ Cell: _____ Work: _____

Please check YES or NO to all of the questions below to determine if your child can receive the Inactivated Influenza Vaccine ("flu shot"). The nurse giving the vaccine will review this information on the day of the vaccine clinic.

	YES	NO
1. Has your child ever had a serious allergic reaction to any component of any flu vaccine (eggs, gentamicin, gelatin and arginine)?	☐	☐
2. Has your child ever had a serious reaction to a previous dose of flu vaccine in the past?	☐	☐
3. Has your child ever had Guillain-Barré syndrome (GBS, i.e., progressive ascending paralysis)?	☐	☐

If you answered YES to any of questions 1, 2 or 3 above about serious allergy, reaction or GBS, flu vaccine may not be safe for your child and s/he WILL NOT receive a flu vaccine.

NOTICE OF DEEMED CONSENT FOR HIV, HEPATITIS B OR C TESTING

VDH is required by § 32.1-45.1 of the Code of Virginia (1950), as amended, to give you the following notice:
1. If any VDH health care professional, worker or employee should be directly exposed to your child's blood or body fluids in a way that may transmit disease, I understand that the law requires my child to give a venous blood sample for further tests. I understand that the tests to be performed are for human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you the result of the test. 2. If your child should be directly exposed to blood or body fluids of a VDH health care professional, worker or employee in a way that may transmit disease, that person's blood will be tested for infection with human immunodeficiency virus (HIV), as well as for Hepatitis B and C. A physician or other health care provider will tell you and that person the result of the tests. I consent to such testing and the release of the test results to the person who was exposed.

CONSENT FOR CHILD'S VACCINATION: In September 2018, will your child be less than 9 years of age? No ☐ Yes ☐
Please complete the next set of questions and sign.

My child is **under 9 years of age** and:

☐ has NEVER been vaccinated against the flu. **Note: Your child will require 2 doses this year.**

☐ has not been vaccinated with at least 2 doses of seasonal influenza vaccine before July 1, 2018. **Note: Your child will require 2 doses this year**

I have read the Vaccination Information Statement (VIS) for the Inactivated Influenza Vaccine (flu shot), I understand the risks and benefits, and I give consent to the Health Department and its authorized staff for my child named at the top of this form to receive the inactivated injectable influenza vaccine (shot). **If needed, I give my consent for my child to receive the second dose approximately 4 weeks after the first.**

Signature of Parent or Legal Guardian: X _____ **Date:** ___/___/___

Turn to Back of Form