



CITY OF PEABODY DEPARTMENT OF HUMAN SERVICES
24 Lowell Street, Peabody, Massachusetts 01960
Tel. (978) 538-5926 Fax: (978) 538-5990

Seasonal Influenza Vaccine 2011-2012
Child Vaccine Administration Record

Information about the child to receive vaccine (please print): *Required Fields

Child's Name: (Last, First, MI)*		Date of birth: * ____/____/____ Month Day Year	Age*	Sex: (Circle)* Male Female
Parent/Legal Guardian's Name: (Last, First)		Parent/Guardian Daytime Phone: * ()		
Street Address: *				
City: *	State: *	Zip: *	Grade/Class: *	

Section 1: Screening for Vaccine Eligibility

The following questions will help us know if your child can get the 2011-2012 seasonal flu vaccine. Please mark YES or NO for each question. If you answer "YES" to one or more of the four questions, your child will not be able to receive the 2011-2012 seasonal flu vaccine unless there is a note from your child's health care provider approving the vaccination. If you answer "NO" to the following questions your child will receive the vaccine unless a concern arises following additional screening. If you are not sure of the answers to these questions, please check with your child's healthcare provider.

	YES	NO
1. Does your child have an allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child have an allergy to gentamicin, neomycin, polymixin or gelatin?	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever had a serious reaction to a flu vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

List other serious allergies: _____

Section 2: Consent

CONSENT FOR CHILD'S VACCINATION:

I have been given a copy and have read or had explained to me the 2011-2012 Vaccine Information Statement for the Seasonal Influenza vaccine and understand the risks and benefits.

I VOLUNTARILY GIVE CONSENT for my child named at the top of this form to get vaccinated with this vaccine. (If this consent is not signed, dated and returned, then your child will not be vaccinated.)



Signature of Parent/Legal Guardian _____

Date: month ____ day ____ year ____

For Clinic /Office Use Only:

Form Reviewed by: _____ Date: _____

Vax Name, Manufacturer, Lot No.& Expiration Date	Seasonal Flu Vaccine Type	Dose No. (Circle)	Injection Site & Route: (Circle)	Date on VIS	Date VIS Given
Vaccine Name: Vaccine Manufacturer: Vaccine lot number:	TIV	Dose #1	IM R ARM L ARM	7/26/11	

Clinic Site Name: _____ MDPH Provider PIN# : _____

Clinic Address: _____

Signature of Vaccine Administrator: _____ Date Vaccine administered: ____/____/____



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Section 3: Permission to Share Information (Optional)

I, _____, give permission to the individual and/or entity that administered the 2011-2012 influenza vaccine
 (Print your name)
 to my child _____ to share copies of the 2011-2012 flu vaccine consent form and vaccination record
 (Print child's full name)
 with my child's school and health care provider named below, as well as with the Massachusetts Department of Public Health and the local board of health in my community. I also give permission for each of these entities to share the 2011/12 seasonal influenza consent form and vaccination record with each other.

My child's health care provider:
 Name: _____

My child's school:
 Name: _____

Address: _____

Address: _____

- This health information is disclosed at my request and to ensure my child is appropriately vaccinated.
- This permission expires at the end of the 2011-2012 school year.
- If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information received may no longer be protected by federal privacy regulations. State privacy regulations cover information received by the MA Department of Public Health and local boards of health.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my child's ability to obtain the vaccination.
- I understand that I may inspect or copy the protected health information to be disclosed under this permission to share.
- Finally, I understand that I may withdraw this permission in writing at any time by sending written notification to:

City of Peabody Health Department, 24 Lowell Street, Peabody, MA 01960
(School/institution/individuals handling withdrawals MUST insert name and address)

However, if I withdraw permission at a later date, any vaccine consent form and vaccine record already shared will not be covered by the withdrawal.



 Printed name of Parent or Guardian

 Signature of Parent or Guardian

 Address

 Date

