Complete, print and submit.

School Flu Vaccine Parent or Guardian Authorization

Instructions for Parent or Guardian: (Flu vaccine information will be stored in the medical record.)
Sign this form only if you would like your child to receive the flu vaccine at school.
Complete one form for each child and return to school by the registration deadline.

Staff Only
Registration_____

Health Insurance Information

Insurance Carrier	Group Number	Policy Number

School Information

School Name	Grade

Child Information

Child Last Name		Child First Name	Child Middle Name
Child Gender as in Medical Record ☐ Male ☐ Female	Child Age	Child Birth Date *(mm-dd-yyyy)*	Child Mayo Clinic Number

Optional: Is there anything we need to know about your child? (May leave blank. Do not include allergies or general fear of needles.)

Parent or Guardian Information (all fields required)

Parent or Guardian Last Name	Parent or Guardian First Name	Parent or Guardian Birth Date *(mm-dd-yyyy)*

Parent or Guardian Address *(Street, City, State, ZIP Code)*

Email	Best Daytime Phone (during school clinic)

Check All That Apply (you **must choose** at least one)

☐ Child is enrolled in a Minnesota Health Care Program:
- MN Medical Assistance (MA)
- Minnesota Care (MNCare)
- Prepaid Medical Assistance Program (PMAP)

☐ Child is American Indian or Native Alaskan
☐ Child does not have health insurance
☐ None of these apply

Answer Yes or No. Your child:

☐ Yes ☐ No Has had a flu shot after June 30 of this year
☐ Yes ☐ No Has a history of Guillain-Barré Syndrome
☐ Yes ☐ No Has had a transplant
☐ Yes ☐ No Has had a severe allergic or anaphylactic reaction to any flu vaccines or their ingredients (such as monosodium glutamate or MSG, gentamicin, gelatin, or arginine)

Your child will not get the flu vaccine at school if any of the above answers in this section are "Yes."

Answer Yes or No. Your child:

☐ Yes ☐ No Has asthma
☐ Yes ☐ No Has any problem breathing through the nose
☐ Yes ☐ No Has had a long-term health problem such as heart, kidney, lung or metabolic disease, anemia, other blood disorders, or any condition that increases the risk of aspiration
☐ Yes ☐ No Is taking prednisone
☐ Yes ☐ No Is taking a medication that weakens the immune system
☐ Yes ☐ No Is 18 years or younger and taking aspirin (or medicine that has aspirin in it) every day
☐ Yes ☐ No Has had chemo or radiation in the last 3 months
☐ Yes ☐ No Has a weak immune system from HIV/AIDS or other diseases that weaken the immune system

Your child will not get the nose spray if any of the above answers in this section are "Yes."

What form of the vaccine would you like administered to your child? (choose only one)
☐ No preference ☐ Prefer nose spray, but shot acceptable ☐ Permission for the nose spray only ☐ Prefer shot, but nose spray acceptable
☐ Permission for the shot only

I have reviewed the risks and benefits on the Vaccine Information Statement (www.immunize.org/vis/) for this vaccine and consent to have my child receive the flu vaccine at school.

Parent or Guardian Signature	Date *(mm-dd-yyyy)*	Relationship to Child

Staff Only

Site used: ☐ LA ☐ RA ☐ LT ☐ RT ☐ Nose	Lot Number	Expiration Date *(mm-dd-yyyy)*	Vaccinator Initials

Did **not** vaccinate: ☐ Did not report ☐ Uncooperative ☐ Information discrepancy _____
☐ Other _____

Print Reset Form