Screening for
Influenza Immunization
Screening and Consent Form (School Form)

Patient's Name: _____ Date of Birth: _____
Address: _____ City: _____ Zip: _____
School Name: _____ City:_____Zip:_____
❑ My child has Medicaid _____❑ My Child does not have medical insurance
❑ My child has Insurance: Company Name: _____❑My Child has been seen at St. Luke's

Please circle the appropriate responses below (required):

Race: White / African American / Hispanic or Latino/ Native Hawaiian / Asian / Alaskan Native / Native American / Other	**Ethnicity:** Not Hispanic or Latino/ Hispanic or Latino	**Gender:** Female / Male

Screening Checklist for Contraindications (Required)	**YES**	**NO**
Is the child sick today?		
Does the child have allergies to medications, food, a vaccine component, or latex?		
Has the child had a serious reaction to a vaccine in the past?		
Has the child ever had Guillain-Barré syndrome?		

I acknowledge that the patient's medical information provided above is correct. I have been given a copy of the Vaccine Information Statement for the vaccines indicated below and the NOTICE of PRIVACY POLICY FORM. I understand the benefits and risk of the vaccines that will be given to the patient. Additional information can be found at: https://www.cdc.gov/vaccines/schedules/ . I understand that participation and receipt of the vaccine(s) through this program is completely voluntary. By signing below, I attest that I am authorized to consent on behalf of the patient and hereby give permission for the patient listed above to receive the vaccines circled below with the understanding that immunization information will be entered into the Idaho Immunization Reminder Information System (IRIS). I understand Idaho IRIS is an opt-out program and I may decline to have information regarding the patient entered into the registry. However, by declining, the patient will be unable to receive vaccines administered by this program.

I understand my child will an Influenza Vaccine.

_____ _____ _____
Name of Parent or Guardian **Date** **Time**

_____ _____
Signature of Parent of Guardian **Relationship to Patient**

VACCINE NAME_____STAFF NAME_____

VACCINE LOT #: _____ DATE: _____

PATIENT LABEL