



U.S. Public Health Services
Hopi Health Care Center
P.O. Box 4000
Polacca, Arizona 86042-4000

**Influenza Vaccination Clinic
2018-2019 PARENTAL CONSENT FORM**

****Regular Seasonal Flu ****

Section 1: Information about Child to Receive Vaccine (please print)

STUDENT INFORMATION		
<u>Last Name</u>	<u>First Name</u>	<u>Middle Initial</u>
<u>STUDENT'S DATE OF BIRTH</u> Month: Day: Year:		<u>STUDENT'S GENDER</u> Male or Female
<u>HHCC Chart #</u> Yes or No		
PARENT/LEGAL GUARDIAN		
<u>Last Name</u>	<u>First Name</u>	<u>Middle Initial</u>

***** If this is the FIRST time your child (8 years old and younger) is receiving the Influenza vaccine, she/he is required to return to clinic for a booster in 4 weeks. Parent(s)/guardian(s) must make this arrangement. *****

The following questions will help us know if your child can get the 2018-2019 Influenza vaccine.

Section 2: Child Health History

	YES	NO
1. Does your child have a serious allergy to eggs?		
2. Does your child have any other serious allergies that you know of? If so, please list:		
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?		
4. Has your child ever had Guillian-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		
5. Does your child have any chronic illnesses such as asthma, seizures, heart disease, or other medical conditions that require frequent doctor visits and medications? If you indicate YES, your child will receive a shot.		

Section 3: Consent for Vaccination

<input type="checkbox"/> <u>I GIVE CONSENT:</u> I have read and understand the VIS on Inactivated Influenza Vaccine.

Signature of Parent/Legal Guardian

Date

Please return to your child's school as soon as possible.

For more information about the 2018-2019 Seasonal Influenza vaccine, please call the Hopi Health Care Center at (928) 737-6257.