



Dartmouth-Hitchcock

NEW HAMPSHIRE SCHOOL (K- 12)

VACCINATION CONSENT FORM

2020-2021 SEASONAL INFLUENZA VACCINATION

SECTION 1: STUDENT INFORMATION

School Name	School Town	Grade	Teacher/Homeroom
Student Name (Last)	(First)	(M.I.)	Student Date of Birth Month _____ Day _____ Year _____
Town	State	Zip	Student Age
Parent/Legal Guardian's Name (please print)			Parent/Guardian Daytime Phone Number

Does your child have OPEN Medicaid with one of the following companies:
Well Sense, Ambetter, NH Healthy Families, Anthem, Harvard Pilgrim, AmeriHealth Caritas or Minute Man Health?
Yes ___ No ___

This program is organized by Dartmouth-Hitchcock (D-H) in partnership with other regional healthcare providers and with funding from the NH DHHS Immunization program. If your child is a patient of D-H primary care, your provider will receive a copy of this form. All children who receive a vaccine will be sent home with a paper record of the vaccination that should be shared with their provider for their records.

My child's primary care provider is at Dartmouth-Hitchcock (or an affiliate)
If yes, which Dartmouth-Hitchcock clinic does your child receive care at?

A provider outside the D-H system provides my child's primary care.

SECTION 2: SCREENING QUESTIONS

Please answer the following questions, to help keep your child safe. If you answer "yes" to any of the questions, please contact your child's medical provider to discuss other ways to receive the vaccine.	YES	NO
1. Does your child have a serious allergy to eggs or any component of the influenza vaccine?		
2. Has your child ever had a severe life-threatening reaction after a dose of the influenza vaccine or been told to not get the influenza vaccine by a healthcare provider?		
3. Has your child ever had Guillain-Barré Syndrome (an autoimmune neurological condition that results in sudden muscle weakness)?		

SECTION 3: CONSENT FOR MY CHILD'S VACCINATION IN SCHOOL

I have reviewed the Influenza Vaccine Information Statement available at: <http://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf> (English version); https://www.immunize.org/vis/vis_flu_inactive.asp (link to other languages).

By signing below, I am giving permission for my child to be vaccinated against influenza at the school clinic.

Yes, I do want my child, named above, to receive the influenza vaccine at school.

Signature of Parent/Legal Guardian _____ Date _____

SECTION 4: ADMINISTRATIVE (INTERNAL) USE ONLY. Vaccine administrator must complete all sections.

BEFORE vaccinating check that you have completed the following (check to confirm done):

- I have asked the student if they are feeling sick or unwell today
 I have reviewed this entire form including the screening questions

Child Not Vaccinated
Reason: _____

Publication date on Vaccine Information Statement (VIS): _____

Provider Name: Mary Hitchcock Memorial Hospital **Provider Address:** 1 Medical Center Drive, Lebanon, NH 03766

Name and Title of Vaccine Administrator: _____ **Signature of Vaccine Administrator:** _____

Vaccine	Manufacturer	Lot Number	Route	Admin Date
			<input type="checkbox"/> IM L Deltoid <input type="checkbox"/> IM R Deltoid <input type="checkbox"/> Other _____	/ /

After vaccination this form was reviewed by: _____