



## Murdock School-Based Health Center Influenza Vaccine Information

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*The Murdock School Based Health Center is offering flu vaccines to Murdock Middle and High school students for the 2018 – 2019 flu season. We had tremendous interest from families last year resulting in 15% of Murdock students being vaccinated! We hope to exceed that number this year! Sign up is easy with the consent form on the back of this page.*

**When:** The Murdock School Based Health Center receives the flu vaccine late September/early October. Once the vaccines are received, the Health Center will call families who would like their child immunized to schedule an appointment. Appointments can be scheduled either during the school day or after school if you prefer to accompany your child.

**Cost:** The flu vaccine is **free** to all students at Murdock Middle and High School who are 18 years old or younger regardless of insurance. The vaccine is supplied by the Massachusetts Department of Public Health Vaccine Program

**How do I sign up my child?** Please fill out the back of this page with your child's information including best daytime number to be reached. Please make sure the form is signed and dated by a parent/guardian and return to school with your child.

**Please call the Murdock School Based Health Center if you have any questions!**

# Influenza (Flu) Vaccine Consent



## Murdock School-Based Health Center

Murdock School Nurse's Suite – Room 218  
 Phone: 978-297-5052 Fax: 978-297-5430  
 Renee Boucher, RN, MSN, NP

Please fill out the following information if you would like your child to receive the influenza/flu vaccine for the 2018-2019 flu season at the Murdock School Health Center. Please read the vaccine information sheet (VIS) located on the Murdock School Health Center's website [www.heywood.org/murdocksbhc](http://www.heywood.org/murdocksbhc) or, [www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf](http://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf). The Health Center will call you to schedule an appointment once the vaccine has been received from the state. Please call the Murdock Health Center if you have any questions.

\_\_\_\_\_  
 Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age

List all of your child's allergies. (If none, write none): \_\_\_\_\_

**Please answer the following:**

	NO	YES
Has your child ever had a serious reaction to a flu vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had a serious allergic reaction to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have an allergy to gentamycin, neomycin, polymixin or gelatin?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have any allergy to latex?	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had Guillain-Barre Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>

By signing my name below, I am acknowledging I have read a copy of the Influenza Vaccine Information Sheet. I understand the risks and benefits associated with the flu vaccine and I have had any questions answered. By signing below, I do not have any questions or concerns at this time, and I authorize the Murdock Health Center to administer the influenza vaccine to my child.

\_\_\_\_\_  
 Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ Best phone # to call

\_\_\_\_\_  
 Parent/Guardian Name – please print \_\_\_\_\_ Relationship to child \_\_\_\_\_ Parent Email

Please fill in the name and address of your child's primary care doctor (PCP) so a copy of the Vaccine Administration Record can be sent to their office.

\_\_\_\_\_  
 Doctor's Name \_\_\_\_\_ Doctor's Address

### Office Use Only

	Date Confirmed	MHC Staff
Confirmed with parent/guardian to administer the flu vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Child has been fever free for the past 24 hours	<input type="checkbox"/>	<input type="checkbox"/>

VFC Eligible			Not VFC Eligible
Is enrolled in Medicaid (includes MassHealth & HMO's)	Does not have health insurance	Is American Indian (Native American) or Alaska Native	Has health insurance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date Given: \_\_\_\_\_ Site: RD  LD  Other: \_\_\_\_\_ Route: \_\_\_\_\_

Manufacturer & Lot #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Administered by: \_\_\_\_\_