STERLING HEALTH CARE
School-Based Health Centers

2025-26 School Year

Annual Influenza Vaccine Consent Form-FLU SHOT

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

STUDENT'S NAME (Last)		(First)	(M.I.)	**STUDENT'S DATE OF BIRTH** **month_____ day_____ year _____**	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	**STUDENT'S AGE**	**STUDENT'S GENDER** **M / F**
ADDRESS				**PARENT/GUARDIAN DAYTIME PHONE NUMBER:**	
CITY	**STATE**	**ZIP**			
STUDENT'S DOCTOR'S NAME (Last, First)		**Address**	**City**	**Zip**	
SCHOOL NAME					

Section 2: Screening for Vaccine Eligibility

Was your child vaccinated with the seasonal influenza vaccine after July 1, 2023?
YES ☐ NO ☐

The following questions will help us to know if your child can get the seasonal influenza vaccine. If you answer "NO" to all four of the following questions, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, your child may be able to get the seasonal influenza vaccine, but we will contact you to discuss your options.
Please mark YES or NO for each question.

	YES	NO
1. Does your child have a serious allergy to eggs?	☐	☐
2. Does your child have any other serious allergies? Please list: _____	☐	☐
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐

STERLING HEALTH CARE

2023-2024 School Year

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:

I have read or had explained to me the 2022-2023 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

☐ **I GIVE CONSENT** to Sterling Health Care and its staff for my child named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then you child will not be vaccinated)

☐ **I DO NOT GIVE CONSENT** to Sterling Health Care and its staff for my child named at the top of this form to be vaccinated with this vaccine.

Signature of Parent/Legal Guardian

_____

Date: Month_____Day_____Year_____

Section 4: Health Insurance Information

Primary Insurance: _____ID #_____Group#_____

Secondary Insurance: _____ID #_____Group#_____

Subscriber Name: _____ Subscriber's date of birth _____

Subscriber gender: _____ Subscriber's phone number_____

Address of the subscriber, if different from that of the patient: _____

Subscribing employer: _____

FOR ADMINISTRATIVE USE ONLY

Section 5: Vaccination Record

Vaccine	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
Influenza	☐ IM ☐ Intranasal	/ /			