STERLING HEALTH CARE
School-Based Health Centers

Annual Influenza Vaccine Student Consent Form-FLU SHOT 2026-2027

Section 1: Information to Receive Vaccine (please print)

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

Section 2: Screening for Vaccine Eligibility

Has your child been vaccinated with the seasonal influenza vaccine after July 1, 2025? 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?	☐	☐

Insurance information:
Do your child have insurance: YES or NO (Please Circle)
Primary Insurance:
ID: **Group:**
Secondary:
ID: **Group:**
Policy Holder Name: **Date of Birth:**
Policy Holder Address if different from patient:

Section 3: Consent

CONSENT FOR STUDENT VACCINATION:
I have read or had explained to me the Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

☐ I **GIVE CONSENT** to Sterling Health Care School Based Health Clinic and its staff for my child named on this form to be vaccinated with this vaccine (if the consent form is not signed, then the child will not be vaccinated).

☐ I **DO NOT GIVE CONSENT** to the Sterling Health Care School-Based Health Clinic or its staff to vaccinate my child with this vaccine.

Signature of Parent/Legal Guardian

_____

Date: Month_____Day_____Year_____

Section 4: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

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