



**Public Health**  
Solutions

### Public Health Solutions Influenza Vaccine Screening/Permission Form 2024-2025

The questions below will be used to decide if you or your child should get *inactivated injectable influenza* vaccine. Answering “yes” to any question does not mean you or your child cannot get flu vaccine today. It means more questions will be asked.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  Female  Male

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ School: \_\_\_\_\_

Insurance (ATTACH COPY)  Medicaid/Managed Care (ATTACH COPY)  Medicare (ATTACH COPY)  No Insurance

**SCREENING QUESTIONS:** Adult/Parent/Guardian: Please answer **ALL** the questions below with **YES** or **NO**. If this form is not completed, signed and returned to school on or before the date of the clinic, vaccine **WILL NOT** be given.

- |  |          |
|--|----------|
| 1. Is the person getting vaccine sick today?                                       | Yes / No |
| 2. Does the person getting vaccine have an allergy to any flu vaccine ingredient?  | Yes / No |
| 3. Has the person getting vaccinated ever had a serious reaction to a flu vaccine? | Yes / No |
| 4. Has the person getting vaccine ever had Guillain Barré syndrome?                | Yes / No |

#### Permission

- I have been given a copy of the 2024-2025 Influenza Vaccine information Statement (VIS), and I have read and/or had the information on inactivated influenza vaccine read to me.
- I have had the chance to ask questions and had those questions answered in a way I can understand.
- I understand the risks and benefits of getting the vaccine and I ask that the influenza vaccine be given to me or the person named above for whom I can legally give permission.
- I understand and agree that Public Health Solutions and the school are not responsible for any unexpected reactions that may happen.
- I understand and agree that it is my responsibility to get medical attention for myself or my child if an unexpected or allergic reaction happens.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Parent/Guardian

#### OFFICE USE ONLY

Nurse Signature: \_\_\_\_\_

Please attach vaccine information sticker and sign form.