COMPLETE THIS FORM ONLY IF YOU WANT YOUR CHILD TO GET THE FLU VACCINE

A. SCHOOL NAME / Name of School

STUDENT NAME (Last)/ First Name (First)

DATE OF BIRTH

AGE

GENDER

RACE

PHONE NUMBER

STREET ADDRESS

CITY

STATE

ZIP

B. In order to determine if your child needs a booster dose, please answer this question:

Did your child receive 2 doses of seasonal flu vaccine since July 2010?

[ ] Yes / Yes [ ] No / No [ ] Unsure / Unsure

C. Please answer all of the following questions:

1. Is the student sick today with fever or respiratory illness?

2. Does the student have a serious allergy to eggs, thimerosal or another component of the flu vaccine?

3. Has the student ever had a serious reaction to a previous dose of flu vaccine?

4. Has the student ever had Guillain-Barré Syndrome (a temporary severe muscle weakness) within 6 weeks after receiving flu vaccine?

D. Please answer all of the following questions:

1. Does the student have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia or another blood disorder?

2. If the student is between the ages of 2 and 4 years old, in the past 12 months, has he/she had wheezing or asthma?

3. Does this student have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high dose steroids, or cancer treatment with radiation or drugs?

4. Does the person have close contact with someone who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?
5. Is the person on long-term aspirin or aspirin-containing therapy? (For example, does the person take aspirin every day?)

هل الشخص يتناول الأسبرين على المدى الطويل أو العلاج المحتوي على الأسبرين؟ (على سبيل المثال، هل يتناول الشخص الأسبرين كل يوم؟)

6. Is the student receiving anti-viral medications?

هل يتلقى الطالب الأدوية المضادة للفيروسات؟

7. Is the person pregnant or could become pregnant in the next month?

هل الشخص حامل أو يمكن أن تصبح حاملا في الشهر القادم؟

8. Has the person received any of the following vaccinations within the past 30 days? MMR, Varicella, or Flu Mist? If yes, give type and date.

هل تلقى الشخص أي من التطعيمات التالية خلال الثلاثين يوما الماضية؟ MMR ، الحمام ، أو ضباب الإنفلونزا؟ إذا كانت الإجابة بنعم ، برجي ذكر النوع والتاريخ.

Recent Vaccinations: ____________________ Date received: ____________________
teletuations الأخيرة تاريخ الاستلام

E. Consent / الموافقة

CONSENT FOR VACCINATION / الموافقة على التلقيح:

I understand I will receive the Flu Vaccine Information Statement and be offered the Cincinnati Health Department Notice of Privacy Practices prior to my child receiving the vaccine.

أدرك أنني سأتلقى بيان معلومات لقاح الأنفلونزا وسأستلم إشعار ممارسات إدارة الخصوصية في وزارة الصحة في سينسيناتي قبل تلقي طفلي اللقاح.

I GIVE CONSENT for the student named at the top of this form to receive the Flu vaccine.

أعطى موافقة للطالب المسمى في الجزء العلوي من هذا النموذج لتلقي لقاح الإنفلونزا.

Signature of Person/Parent/Legal Guardian - توقيع الشخص/ولي الأمر/الوصي القانوني
Date / التاريخ: month / الشهر ________________ day / اليوم ________________ year / السنة ________________

Print Name of Parent Legal/Guardian - طباعة اسم الولي القانوني/الوصي

Parent Cell Phone Number - رقم الهاتف الخلوى

F: Vaccination Record (FOR ADMINISTRATIVE USE ONLY) / سجل التطعيم (بالاستخدام الإداري فقط):

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date Dose Administered</th>
<th>Route</th>
<th>Lot Number</th>
<th>Name and Title of Vaccine Administrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>2021 Seasonal Flu</td>
<td>/ /2021</td>
<td>L Arm R Arm</td>
<td>□ IM</td>
<td></td>
</tr>
<tr>
<td>Booster Dose</td>
<td>/ /2021</td>
<td>L Arm R Arm</td>
<td>□ IM</td>
<td></td>
</tr>
</tbody>
</table>

Flu consent rev 4/14, 6/18, 6/19, 8/21