



CENTRAL LINCOLN COUNTY SCHOOL SYSTEM

SEASONAL FLU LETTER TO PARENTS

In February of 2009 the Federal Centers for Disease Control and Prevention (CDC) recommended that children 6 months to 18 years of age get seasonal (regular) influenza vaccine starting with the 2009-2010 influenza (flu) season. Children under the age of 9 who have not received seasonal influenza vaccine in the past will need two doses of vaccine given 4 weeks apart.

The Maine Department of Education (DOE) and the Maine Centers for Disease Control and Prevention (Maine CDC) are offering seasonal Influenza vaccine to children through special school vaccination clinics. We are urging parents of younger students to attend the clinic with their children and all parents should verbally prepare their children for the shot.

If you want your child to receive the seasonal influenza vaccine please complete the attached permission form and return it to your school nurse as soon as possible. If you have questions please contact your school nurse.

Sincerely,

Central Lincoln County School System/Maine AOS No. 93
The Maine CDC and Department of Education

Seasonal influenza vaccine permission form - Inactivated

I was given a copy of the Vaccine Information Sheet and have read it. I understand the benefits and the risks of the Seasonal Influenza Vaccination and ask that the vaccine be given to my child.

I give permission for my child to receive seasonal influenza vaccine.

Signature of Parent or Guardian: _____ Date: _____

PLEASE RETURN THIS FORM AS SOON AS POSSIBLE

Central Lincoln County School System 2009-2010 Seasonal Influenza Vaccine Clinic

STUDENT NAME: _____ BIRTHDATE: _____ AGE _____

ADDRESS: _____ City: _____

TELEPHONE: _____

Please provide a phone number where you can be reached on the day of the clinic: _____

SCHOOL NAME: _____

HEALTH SCREEN

The following questions will help us determine if there is any reason your child should not receive the SEASONAL influenza vaccination on clinic day. Please answer every question.

- | | | |
|---|-----|----|
| 1.) Is this child ill? | YES | NO |
| 2.) Does this child have an allergy to eggs? | YES | NO |
| 3.) Has this child ever had a serious reaction to immunizations in the past? | YES | NO |
| 4.) Has this child ever had Guillain-Barre Syndrome? | YES | NO |
| 5.) Could this child be pregnant? (grade 6 and up) | YES | NO |
| 5.) If your child is 8 yrs of age or younger have they received 2 or more previous flu shots? | YES | NO |

I give permission for this form to be sent to my child's primary care provider YES NO

Health Insurance Company (if any) and Number

Name of child's health care provider (doctor, nurse practitioner):

Phone number of child's health care provider: _____

FOR OFFICE USE ONLY:

Date Given	Manufacturer	Lot #	Site	Dosage	Provider Signature
	Sanofi-pasteur <input type="checkbox"/> <input type="checkbox"/>		RD LD	0.5cc IM	