The Influenza Vaccine/Flu Shot is required for students in the boarding school environment. Cushing Academy Health Services holds an annual Influenza clinic each fall to administer the intramuscular flu vaccine to the vast majority of students, faculty, and staff. When the vaccine is administered, all vaccine recipients will receive a Vaccine Information Sheet (VIS) reviewing the risks and benefits.

Vaccination exemptions may be made for (1) sincerely-held religious beliefs, for which Cushing Health Services can provide the attestation form upon request, or (2) medical reasons specified in a letter signed by your student's primary care provider. If your student has already received the influenza vaccine, please upload an immunization record to the Immunization Record in the SNAP Health Portal.

(the "Student"), I authorize the Student to participate in the Influenza Clinic. I understand that my consent allows Walgreens Pharmacy and its healthcare providers to administer the Influenza vaccine to the Student.

I understand that Walgreens Pharmacy, not the Academy, is responsible for implementing and running the Influenza Clinic. Though the Academy will take reasonable measures to help ensure the Student's safety while participating in the Influenza Clinic, I understand and agree that the Academy is not responsible for and cannot guarantee the student participants' health and safety. I agree that before the Student participates in the Influenza clinic, I will discuss the appropriate health and safety precautions for participating in the Influenza Clinic and receiving the Influenza vaccine.

I recognize that there are dangers and risks to which the Student may be exposed by participating in the Influenza Clinic. I understand that these risks include, but are not limited to, side effects of receiving the Influenza vaccine (e.g., pain at the site of the injection, tiredness, headache, muscle and joint aches, nausea and vomiting, fever or chills, severe allergic reactions, and other bodily injuries), as well as the potential negligence of Cushing and/or Westminster Pharmacy and its healthcare providers. As the Student's parent(s)/legal guardian(s), I assume these risks by giving the Student my permission and consent to participate in the Influenza Clinic.

In consideration of the Student being permitted to participate in the Influenza Clinic, I agree, on my own behalf and that of the Student and our heirs, executors, administrators, personal representatives, successors, and/or assigns ("Releasors"), to forever release, hold harmless, and covenant not to sue the Academy, its employees, officers, directors, volunteers, members, trustees, and representatives, from any claims, suits, liabilities, or actions, including, but not limited to, claims of negligence (but not gross negligence), which Releasors may have now or in the future, which arise directly or indirectly out of the Student's participation in the Influenza

Clinic. These provisions do not govern any claims that cannot be released by private agreement.

I have read this form in its entirety and understand what it means. By signing this form, I affirm that I have legal custody of the Student and am authorized to sign on the Student's behalf. If I am signing this form via SNAP Health, I acknowledge and agree that my electronic signature has the same legal effect and validity as a written signature and that this form is valid and will be given the same legal effect as a written and signed form.

As the parent(s)/guardian(s) of

Student Name:_____

Student's Date of Birth: _____

Influenza Vaccination (School-Required Vaccine): Please select ONE of the following options

- ☐ Yes, I would like to have my student vaccinated at the clinic. Please complete page 3 of this document
- ☐ No, my student will be getting vaccinated at home
- ☐ No, my student is already vaccinated (the vaccine must have been given after 7/1/2026)
- ☐ No, I would like my student to have a religious waiver
- ☐ No, I would like my student to have a medical waiver (please send in a signed letter from the student's provider.

Parent/Guardian Signature:_____Date:___/____/_____

Parent/Guardian Printed Name:_____

Please complete the following sections on the next two pages:

- Section A
- Section C
- Section D please sign and leave the rest of the section blank. We will supply the insurance card to Westminster Pharmacy.

Vaccine Administration Consent Form

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Section A (Please print clearly.)

First name: Last name:

Age: Date of birth: Gender (check one): ☐ Female ☐ Male ☐ Non-binary

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander Ethnicity: ☐ Hispanic ☐ non-Hispanic

Home address:

City: State: ZIP Code:

Email address: Phone number:

Primary care physician name: Physician phone: Physician fax:

Please check the vaccinations you wish to receive today.

☐ Seasonal Influenza	☐ Hepatitis B	☐ Pneumococcal	☐ Meningococcal
☐ COVID-19	☐ Chickenpox (varicella)	☐ Tetanus/TDap	☐ MMR
☐ Hepatitis A	☐ HPV	☐ Shingles (zoster)	☐ Other

Section B (The following questions will help us determine your eligibility for vaccination today.)

General Vaccine Screening Questions	Yes	No
1. Do you feel sick today?	☐	☐
2. Do you have any health conditions such as heart disease, diabetes or asthma? If yes, please list:	☐	☐
3. Do you have allergies to latex, medications, food or vaccines (e.g., eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list:	☐	☐
4. Have you ever had a reaction (allergic or otherwise) after receiving an immunization, including fainting or feeling dizzy?	☐	☐
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré Syndrome (a condition that causes paralysis) or other nervous system problem?	☐	☐
6. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS or transplant)?	☐	☐
7. For women: Are you pregnant or considering becoming pregnant in the next month?	☐	☐
Live vaccines	**Yes**	**No**
8. Have you received any vaccinations or skin tests in the past four weeks? If yes, please list:	☐	☐
9. Are you currently on home infusions, weekly injections such as Humira™ (adalimumab), Remicade™ (infliximab) or Enbrel™ (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	☐	☐
10. Are you currently taking high-dose steroid therapy (prednisone > 20 mg/day or equivalent) for longer than two weeks?	☐	☐
11. Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?	☐	☐
12. Are you currently taking any antibiotics, antiviral or antimalarial medications? (Typhoid only)	☐	☐
13. Do you have a history of thrombocytopenia or thrombocytopenic purpura? (MMR only)	☐	☐
14. Are you receiving aspirin therapy or aspirin-containing therapy? (18 years of age and younger only)	☐	☐
15. Do you have a nasal condition serious enough to make breathing difficult (e.g., very stuffy nose)?	☐	☐

Vaccine Administration Consent Form

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Section C

COVID-19 Vaccine Screening Questions	Yes	No
16. Have you ever received a dose of COVID-19 vaccine? If yes, which product? ☐ Pfizer ☐ Moderna ☐ Janssen (Johnson & Johnson) ☐ Another product If yes, will this be your ☐ 2nd dose or ☐ 3rd dose Date of last dose:	☐	☐
17. Have you ever had an allergic reaction to a component of a COVID-19 vaccine, including either of the following:		
• Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures	☐	☐
• Polysorbate, which is found in some vaccines, film-coated tablets and intravenous steroids	☐	☐
- A previous dose of COVID-19 vaccine (This includes a severe allergic reaction, such as anaphylaxis, that required treatment with epinephrine or EpiPen™, or that caused you to go to the hospital. It also includes an allergic reaction that caused hives, swelling or respiratory distress, including wheezing.)		

18. Check all that apply to you:

- ☐ Am a female between ages 18 and 49 years old
- ☐ Am a male between ages 12 and 29 years old
- ☐ Have a history of myocarditis or pericarditis
- ☐ Had a severe allergic reaction to something other than a vaccine or injectable therapy such as food, pet, venom, environmental or oral medication allergies
- ☐ Had COVID-19 and was treated with monoclonal antibodies or convalescent serum
- ☐ Diagnosed with multisystem inflammatory syndrome (MIS-C or MIS-A) after a COVID-19 infection
- ☐ Have a weakened immune system (e.g., HIV, cancer) or take immunosuppressive drugs or therapies
- ☐ Have a bleeding disorder
- ☐ Take a blood thinner
- ☐ Have a history of heparin-induced thrombocytopenia (HIT)
- ☐ Am currently pregnant or breastfeeding
- ☐ Have received dermal fillers
- ☐ History of Guillain-Barré Syndrome (GBS)

Section D (Consent and Release)

I understand the benefits and risks of the vaccination(s) as described in the Vaccine Information Statement (VIS), a copy of which was provided with this Consent and Release. I request the vaccine(s) be given to me or to the person named below, a minor for whom I represent that I am authorized to sign this Consent and Release.

Signature of person to receive vaccine and VIS: Date:

(or parent/guardian, if recipient is younger than 18 years)

Insurance information and authorization:

☐ I hereby authorize the pharmacy to bill my insurance on my behalf for the immunizations and receive payment.

Non-medicare	Pharmacy	Medical	Medicare Card No. (Red, White and Blue Card)
Insurance plan name			
Member/recipient ID			
RX Bin		NA	
RX PCN		NA	
Group No.			

Vaccine	MFR	Date admin.	Vaccine lot No.	Exp. date	Dosage	Injection site	VIS/EUA date	Dose in series
COVID-19								
Influenza								
Other								

Immunizer name (print): **Immunizer signature:**

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