Influenza Immunization Clinic Consent Form

School Name _____ Clinic Date _____

In order for your child to obtain the adolescent vaccinations during this school based clinic, you must
1. **Complete** both sides of this form, 2. **Provide** previous vaccination records, and 3. **Sign & Date** this form.

A. INFORMATION ABOUT PERSON RECEIVING VACCINE (PLEASE PRINT)

Person to be vaccinated's Name _____Last _____ First _____Middle

Person to be vaccinated's Birth Date_____ Age _____ Gender *Male* *Female*

Parent/Guardian Name Last _____ First _____ Relationship _____

Person to be vaccinated's Address _____ City _____ Zip Code _____

B. VACCINE ELIGIBILITY SCREENING (PLEASE CHECK APPROPRIATE BOX)

☐ **Medicaid** A child, 0 through 18 years of age, who has Medicaid as primary insurance.
☐ **American Indian/Alaskan Native** A child, 0 through 18 years of age, who identifies as an American Indian or Alaskan Native, regardless of insurance.
☐ **No Health Insurance** A child, 0 through 18 years of age, who does not have health insurance.
☐ **Insurance Does Not Cover Vaccines (Underinsured)** A child, 0 through 18 years of age, who has commercial (private) health insurance but the coverage does not include vaccines, children whose insurance covers only selected vaccines (these children are categorized as underinsured for non-covered vaccines only), or children whose insurance caps vaccine coverage at a certain amount (once that coverage amount is reached, these children are categorized as underinsured).
☐ **Fully Insured** A child, 0 through 18 years of age, who has health insurance which provides coverage for vaccines. If primary insurance denies the claim and Medicaid is a secondary insurance, the healthcare provider will make the adjustment and bill Medicaid.
☐ **Adult (19 years of age and older)**

C. VACCINE HEALTH SCREENING (CIRCLE YES OR NO)

Please answer all questions about the person to be vaccinated who will be receiving the vaccine(s). Answers will determine whether the person to be vaccinated can be vaccinated at this time.

Yes No 1. Does the person to be vaccinated have an allergy to eggs or to a component of the flu vaccine?
If yes, please explain _____
Yes No 2. Has the person to be vaccinated had a serious reaction to influenza vaccine in the past?
Yes No 3. Has the person to be vaccinated had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (i.e. diabetes), or a blood disorder?
Yes No 4. Has the person to be vaccinated ever had Guillain-Barré Syndrome?
Yes No 5. Does the person to be vaccinated have cancer, leukemia, AIDS, active tuberculosis or any other immune system problem?
Yes No 6. Has the person to be vaccinated taken cortisone, prednisone, other steroids or anticancer drugs or had radiation treatments in the past three (3) months?
Yes No 7. Is the person vaccinated receiving antiviral medications?
Yes No 8. Is the person to be vaccinated less than 2 or over 49 years of age?
Yes *No* 9. *For persons age 2-4 years only* Has a healthcare provider told you the child has asthma or wheezing?
Yes No 10. Is the person to be vaccinated pregnant or is there a chance she could become pregnant during the next month? *If yes, person should receive inactivated influenza vaccine (IIV).*
Yes No 11. Has the person to be vaccinated received vaccinations in the past four (4) weeks?
If yes, please list vaccines _____

If yes to questions 5-11, it is safe to vaccinate with the inactivated influenza vaccine (IIV) if the live attenuated vaccine is not recommended.

D. CONSENT TO VACCINATE (CHECK BOX)

I have been given a copy and I have read, or had explained to me, the information in the Vaccine Information Statement(s) for the influenza vaccine my child will be receiving. I have had a chance to ask questions and fully understand the benefits and risks of each of the indicated vaccine and ask that the following vaccine be given to my child on the scheduled school clinic date. I understand that a licensed health care professional will review my responses on this questionnaire and will offer the most appropriate vaccine.

☐ Influenza

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I give permission to the _____ County Health Department, the Indiana State Department of Health, and/or their designees to vaccinate the person to be vaccinated named on this form.

Signature of Parent/Guardian _____ Date _____

E. TO BE COMPLETED BY PERSON ADMINISTERING VACCINE

Vaccine	Manufacturer/Lot Number/ Expiration Date	Signature of Vaccinator	Site	Route	Date of VIS
IIV			Left or Right Deltoid	IM	
LAIV4				Intranasal	

Entered into CHIRP by _____ Date _____