OFFICE USE ONLY	Initials	Date
Entered in IRIS		
Billed		

Cedar County Public Health

400 Cedar St. Tipton, IA

(563) 886-2226

CHILD

2014/2015 Influenza Vaccine Consent Form & Administration Record-Child

SECTION 1

NAME: (Last) (First) (MI)		DATE OF BIRTH:	AGE:
ADDRESS: BOX#:		GENDER: (circle one) Male Female	
CITY: STATE: ZIP:		PHONE NUMBER:	
CHILD'S PHYSICIAN:		CLINIC:	

PAYMENT INFORMATION

CHECK ONE	PAYMENT	AMOUNT	IDENTIFICATION NUMBER
	Private Pay ☐ Cash ☐ Check	$25	
	VFC	0	
	Medicaid	0	

SECTION 2

	YES	NO
1. Is the child allergic to eggs, gelatin, or antibiotics?		
2. Does the child have any severe or life threatening allergies?		
3. Has the child ever had a serious reaction to a previous dose of flu vaccine?		
4. Has the child ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness)?		

PLEASE COMPLETE REVERSE SIDE

Answer the following questions if you would like the FluMist vaccine. (Subject to availability)

	YES	NO
1. Is the child under 2 years of age?		
2. Does the child have one of the following conditions: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nervous system or blood?		
3. Does the child have a weak immune system (HIV/AIDS, cancer, meds used to treat cancer, steroids)?		
4. If the child is under age 5, in the past 12 months, has a health-care provider told you that the child had wheezing or asthma?		
5. Has the child received any other vaccines in the past 28 days (ex: MMR, chickenpox, flu nasal spray)		
6. Does the child have close contact with someone who needs special care for an extremely weakened immune system?		
7. Is the child pregnant?		

SECTION 3
Complete for children LESS than 9 years old

If you answer "yes" to either question, child will need only one dose of the influenza vaccine.

	Unsure	YES	NO
1. Did the child receive the flu vaccine during the 2013/2014 flu season?			
2. Has the child received at least 2 doses of flu vaccine since July 1, 2010?			

Consent for Vaccination

I have read or had explained to me the Vaccine Information Statement for the 2014/2015 influenza vaccine (8/19/2014) and understand the risks and benefits. I understand that if my child is under the age of 9, he/she may require a second dose of this vaccine. I give consent to Cedar County Public Health to vaccinate the person named above and record in the state's immunization registry (IRIS).

If eligible for Medicare or Medicaid benefits I certify that the information I provided for payment is correct. I authorize release of all records required to act on this request. I authorize Medicare or Medicaid to make payments directly to the Cedar County Public Health Nursing Service.

_____ _____

Signature Date

FOR CLINIC USE ONLY

		First Dose Sticker
	Left Arm	
	Right Arm	
	Left Thigh	
	Right Thigh	
	Intranasal	

Nurse's Signature: Date:

		Second Dose Sticker (if necessary)
	Left Arm	
	Right Arm	
	Left Thigh	
	Right Thigh	
	Intranasal	

Nurse's Signature: Date: