INFLUENZA VACCINE ADMINISTRATION RECORD & CONSENT

Children 3 – 18 years old

Information about person to receive vaccine PLEASE PRINT:

_____ _____ _____/_____/_____
Last Name First Name **DATE OF BIRTH**

_____ _____ _____
Address Apt/Suite Age

_____ _____ _____ (_____) _____-_____
City State Zip Area Code & Phone Number

1.	Does person to be vaccinated have an allergy to eggs?	Yes	No
2.	Does the person to be vaccinated have an allergy to Gentamycin, latex, gelatin or thimerosal?	Yes	No
3.	Has the person to be vaccinated ever had a serious reaction to an influenza vaccine?	Yes	No
4.	Has the person to be vaccinated ever had Guillain-Barré Syndrome?	Yes	No
5.	Does the person to be vaccinated have a seizure disorder?	Yes	No
6.	Has the person to be vaccinated had asthma, wheezing or taken medicine for asthma (including inhalers) **in the past year**?	Yes	No
7.	Has the person to be vaccinated ever had a health problem with lung disease, heart disease, kidney disease, metabolic disease (e.g. diabetes), a blood disorder or is currently receiving aspirin therapy?	Yes	No
8.	Does the person to be vaccinated have cancer, leukemia, AIDS or any other immune system problem?	Yes	No
9.	Has the person to be vaccinated taken cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments (does not include x-rays) **in the past three (3) months**?	Yes	No
10.	Has the person to be vaccinated received a transfusion of blood or blood products or been given a medicine called immune (gamma) globulin **in the past year**?	Yes	No
11.	Is the person to be vaccinated pregnant or is there a chance she could become pregnant **during the next month**?	Yes	No
12.	Has the person to be vaccinated received a Measles Mumps Rubella (MMR), Varicella (chickenpox), Yellow Fever or FluMist vaccine **in the past four (4) weeks**?	Yes	No
13.	Does the person to be vaccinated have close contact with anyone who has a weakened immune system who is in the hospital **in a protective environment** (e.g. an individual who has had a bone marrow transplant)? Please describe: _____	Yes	No

Please turn over →

Please Circle (For Statistical Purposes Only)_____

A) **Sex:** Male Female

B) **Race:** White African American Asian/Pacific Islander Asian Indian Other

C) **Ethnicity:** Non Hispanic Hispanic Unknown

Child's Insurance Information: (please circle)

Private Insurance CHIP Medicaid (State Insurance) No insurance
Insurance Company: _____

Parent or Guardian Consent:

I give permission for my child to receive a 2014/15 influenza vaccine. I understand vaccine information may be shared with my child's primary care provider. I understand I have the right to revoke this consent anytime before the vaccine is given. I understand I have the right to review my child's health information. I received a copy of the Vaccine Information Statement.

Parent/Guardian (please print): Last _____ First _____

Parent/Guardian Signature: _____Date_____

Relationship to child: (please circle) Mother Father Legal Guardian

For Clinic/Office Use Only

Clinic Site: _____

Date Vaccine Administered: _____

Vaccine Manufacturer: Sanofi Pasteur GSK MedImmune

Lot Number_____ Exp. Date: _____

Dosage: 0.5cc (IIV) / .2cc (FluMist) VIS LAIV 8/19/14

Site of Injection: RD, IM LD, IM Intranasal IIV 8/19/14

Signature of Vaccine Administrator: _____

Payment Type:

Cash _____ Check _____ Railroad _____

Credit Card _____ No Charge _____ Medicare _____