CHILD Annual Influenza Vaccine Consent Form 2016-2017

Section 1: Information about Child to Receive Vaccine (please print)

Child's NAME (Last)	(First)	(Middle initial)	**Child's DATE OF BIRTH month_____ day_____year_____**
STREET ADDRESS	**AGE**	**GENDER MALE FEMALE**	
City State	**Zip**	**Phone**	
PARENT/LEGAL GUARDIAN'S NAME (Last)	**(FIRST)**	**PARENT/GUARDIAN DAYTIME PHONE NUMBER**	

Section 2: Vaccination Fee –(Check only ONE box)

MY CHILD

- ☐ **Is enrolled in ALLKIDS (CHIP). Child's ALLKIDS number_____**
- ☐ **Is enrolled in Medicaid. Child's Medicaid number:_____**
- ☐ **Does not have health insurance OR health insurance does not cover cost of vaccinations = Vaccination Fee $10**
- ☐ **is American Indian or Alaskan Native = Vaccination Fee $10**
- ☐ **HAS health insurance covering cost of vaccinations = Vaccination fee $25**

Section 3: Screening for Vaccine Eligibility:

The following four questions will help us to know if your child can receive the influenza vaccine.		
1. Does your child have an allergy to eggs?	YES	NO
2. Does your child have any other serious allergies? Please list: _____	YES	NO
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	YES	NO
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	YES	NO
5. Is your child on aspirin therapy or aspirin-containing therapy (for example, does your child take aspirin every day)?	YES	NO
6. Is your child sick today?	YES	NO
7. Is your child receiving influenza antiviral medications?	YES	NO

Section 4: CONSENT FOR CHILD'S VACCINATION:

I have read or had explained to me the 2016-2017 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits. **I GIVE CONSENT** to the MONROE COUNTY HEALTH DEPARTMENT and its staff for the person named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then child will not be vaccinated)

Signature of Parent/Legal Guardian _____ Date: month_____day_____year_____

Section 5: Vaccination Record -FOR ADMINISTRATIVE USE ONLY

Influenza Vaccine	Route	Date Dose Administered	Site	Lot Number/Exp #	Name and Title of Vaccine Administrator
VFC PP	Infant IM		Deltoid R L Thigh		