FLU 23/24

Monroe County Health Department

CHILD Annual Influenza Vaccine Consent Form 2023-2024

Section 1: Information about Child to Receive Vaccine (PLEASE PRINT)

Child's Name (Last)	(First)	Child's Date of Birth Month _____ Day _____ Year _____
Street Address	Age	Gender at Birth MALE FEMALE
City State	Zip	Phone
PARENT/LEGAL GUARDIAN'S NAME		Insurance Type

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

- ☐ **MEDICAID Insurance & Number** _____
- ☐ **NO Insurance, Insurance does NOT cover cost of vaccinations, American Indian or Alaskan Native = Vaccination Fee $15**
- ☐ **HAS health insurance covering cost of vaccinations = Vaccination fee $35**

Section 3: Screening for Vaccine Eligibility: MUST answer YES or NO for each question.

1. Do you have any of the following: asthma, diabetes (or other types of metabolic disease), disease of the lungs, heart, kidneys, liver, nerves, blood or weakened immune system? (Example: HIV, cancer, medications such as steroids or those used to treat cancer)	YES	NO
2. Does your child have an allergy to eggs?	YES	NO
3. Does your child have any other serious allergies? Please list: _____	YES	NO
4. Has your child ever had a serious reaction to a previous dose of flu vaccine?	YES	NO
5. 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
6. Is your child on aspirin therapy or aspirin-containing therapy? (Ex: daily aspirin)	YES	NO
7. Is your child sick today?	YES	NO
8. Is your child receiving antiviral medications? (Ex: Paxlovid, Valtrex, Tamiflu, Relenza, etc.,)	YES	NO
9. Has your child received a positive Covid test in the past 10 days?	YES	NO
10. Has your child received any vaccinations in the past 14 days?	YES	NO
11. Does your child have a history of fainting/passing out from needles or shots?	YES	NO

Section 4: CONSENT FOR CHILD'S VACCINATION:

I have read or had explained to me the 2023-2024 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. **CONSENT FORM MUST BE SIGNED.**

Signature of Parent/Legal Guardian_____ **Date: month** _____ **day** _____ **year**_____

Section 5: Vaccination Record - FOR ADMINISTRATIVE USE ONLY

VIS Date:

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