FLU 24/25

Monroe County Health Department

CHILD Annual Influenza Vaccine Consent Form 2024-2025

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 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? (Ex: daily aspirin)	YES	NO
6. Is your child sick today?	YES	NO
7. Is your child receiving antiviral medications? (Ex: Paxlovid, Valtrex, Tamiflu, Relenza, etc.,)	YES	NO
8. Has your child received any vaccinations in the past 14 days?	YES	NO
9. 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 2024-2025 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 given at time of visit.

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		