INFLUENZA VACCINE CONSENT FORM

PATIENT INFORMATION

Patient's Name: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Ethnicity:
☐ Hispanic or Latino
☐ American Indian or Alaskan Native
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ White
☐ Other
☐ Unknown

Phone #: _____ Alternate Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____

RESPONSIBLE PARTY (if information is the same as patient, please skip this section)

Guardian's Name: _____

Phone #: _____ Alternate Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Insurance: _____ Subscriber: _____

ID #: _____ Group #: _____

IMMUNIZATION SCREENING QUESTIONNAIRE

☐ yes ☐ no 1. Is the patient being vaccinated currently sick or experiencing a high fever?

☐ yes ☐ no 2. Does the patient have allergies to medications, food, a vaccine component, or latex?

☐ yes ☐ no 3. Has the patient had a serious reaction to a vaccine in the past?

☐ yes ☐ no 4. Has the patient had a health problem with lung, heart, kidney, metabolic disease (e.g. diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?

☐ yes ☐ no 5. If the patient to be vaccinated is between the ages of 2 and 4, has a healthcare provider told you that the child has wheezing or asthma in the past 12 months?

☐ yes ☐ no 6. If the patient is an infant, have you ever been told he or she has intussusceptions?

☐ yes ☐ no 7. Has the patient, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?

☐ yes ☐ no 8. Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?

☐ yes ☐ no 9. In the past 3 months, has the patient taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had any radiation treatments?

☐ yes ☐ no 10. In the past year, has the patient received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?

☐ yes ☐ no 11. Is the patient pregnant or is there a chance she could become pregnant during the next month?

☐ yes ☐ no 12. Has the patient received any vaccinations in the past 4 weeks?

I have been offered a copy of the "Vaccine Information Statement(s)" checked above. I have read, have had explained to me and understand, the information in the "Vaccine Information Statement(s)". I ask that the flu vaccine be given to me or to the person named below for whom I the parent or guardian or am otherwise authorized to make this request. I consent to the inclusion of this immunization data in the Kansas Immunization Registry for myself and on behalf of the person named above.

Signature of Patient or Parent/Guardian:_____ Date:_____

FOR OFFICE USE ONLY

☐ Flublok ☐ Fluzone HD ☐ Fluzone Regular Site of Injection: _____

Lot #: Expiration Date: _____ Administered By:_____