FLU VACCINE CONSENT

Date_____ Child's age _____ Insurance Company Name _____

I, (parent's name)_____ hereby consent to the injection of seasonal influenza vaccine, 2018-2019 type flu strain for (child's name) _____ I release Smita P Mengers, MD and Dr Wendy VanBronkhorst, MD from any possible medical complications related to receiving the Influenza vaccine this date.

I understand that adverse reactions are frequent and usually mild, but they may occur. The most serious complication could be GUILLIAM-BARR SYNDROME (GBS). In 1976 flu vaccine was associated with GBS, Influenza vaccine since then have not been clearly linked to GBS. However, if there is a risk of GBS from current influenza vaccines, it is estimated at 1-2 cases per million persons vaccinated.

I hereby that I have had the opportunity to review the CDC's 2018-2019 VIS and answered the CDC screening questionnaire before receiving the vaccine.

PLEASE CIRCLE YOUR ANSWER

1.- Is the first time that your child is receiving the flu vaccine?	YES	NO
2.- Is your child allergic to eggs, egg products, gelatin, MSG, gentamicin or arginine?	YES	NO
3.- Did your child recently use a nebulizer treatment or an inhaler?	YES	NO

If you circle yes to the last question, when was the last time your child used any asthma medication? _____

I understand that my insurance company may not cover the flu vaccine and I will be responsible for the balance in full.

Parent signature _____

**********FOR OFFICE USE ONLY **********

	Nl	Abnl	Finding
General	☐	☐	_____
Ears/TM	☐	☐	_____
Lymph nodes	☐	☐	_____
Nares	☐	☐	_____
CV	☐	☐	_____
Chest	☐	☐	_____
Lungs	☐	☐	_____

Lot # _____
Exp _____
Dose _____
Site _____
Temp _____

_____
Physician Signature

_____
Administrator signature

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month / day / year

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to a component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4066.pdf • Item #P4066 (9/18)