

2014 - 2015 Flu Vaccination Consent Form

Last Name <input style="width: 95%; height: 20px;" type="text"/>	First Name <input style="width: 95%; height: 20px;" type="text"/>	MI <input style="width: 15px; height: 20px;" type="text"/>
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Home Address (House Number And Street Name) <input style="width: 98%; height: 20px;" type="text"/>	Apt. Number <input style="width: 20px; height: 20px;" type="text"/>
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City <input style="width: 98%; height: 20px;" type="text"/>	ZIP Code <input style="width: 20px; height: 20px;" type="text"/>	Gender: <input type="radio"/> Male <input type="radio"/> Female
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Area Code <input style="width: 15px; height: 20px;" type="text"/> - Phone Number <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/>	Date Of Birth (example 05/18/1980) <input style="width: 15px; height: 20px;" type="text"/> / <input style="width: 15px; height: 20px;" type="text"/> / <input style="width: 15px; height: 20px;" type="text"/>
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Mother's First Name <input style="width: 98%; height: 20px;" type="text"/>	Month <input style="width: 15px; height: 20px;" type="text"/> / Day <input style="width: 15px; height: 20px;" type="text"/> / Year <input style="width: 15px; height: 20px;" type="text"/>
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Race / Ethnicity Asian Black / African American Hispanic / Latino White Other
Choose One Native Hawaiian / Pacific Islander American Indian / Alaskan Native Multi - Race

1) Do you have a fever or are you sick today? Yes No

2) Are you pregnant or do you think you may be pregnant? Yes No

3) Have you had a serious reaction to flu vaccine requiring medical help? Yes No

I CONSENT TO THE VACCINATION PROVIDED. Signature	If under 18 years of age, PRINT name of parent or legal guardian
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4) Do you have a severe allergy to eggs? [If YES, See Egg Allergy Guidelines] Yes No

5) Do you have an allergy to thimerosal? Yes No

6) Do you have an allergy to latex? [If YES, Do NOT Administer GSK - Fluorix] Yes No

7) Have you ever had Guillain-Barré Syndrome (GBS)? Yes No

8) Have you received any of these vaccines in the last 4 weeks? [MMR, Varicella, LAIV, Shingles] Yes No

9) Do you have any of the following medical conditions? [If YES, Administer IIV ONLY] Yes No

Heart, Lung, Kidney, or Liver Disease; Asthma; Cancer; Metabolic disease (i.e. diabetes);
Blood Disorders (i.e. leukemia, lymphoma, sickle cell disease); Immune System Disorder (i.e. HIV / AIDS, steroid therapy)

10) Is the person to be vaccinated between 2-49 years old? (Verify Age) * [If NO, Administer IIV] Yes No

If the vaccination is for a child, ask these questions: [If YES to either, Administer IIV ONLY]

11) If child is < 5 years, have they been diagnosed with wheezing in the last 12 months? Yes No N/A

12) Is child taking long term medicine therapy containing ASPIRIN? Yes No N/A

13) For persons under 19 years, select VFC eligibility. (choose one) Uninsured Medi-Cal / CHDP
 American Indian / Alaskan Native Not VFC eligible

Flu Vaccine VIS Date: 08/19/2014	Manufacturer and Lot Number	Dosage	Site	Initials
<input type="radio"/> INACTIVATED Flu Shot <input type="radio"/> LIVE Nasal Spray	Manufacturer <input type="radio"/> GSK <input type="radio"/> MI <input type="radio"/> NOV <input type="radio"/> SP	<input type="radio"/> 0.25 mL <input type="radio"/> 0.50 mL <input type="radio"/> 0.20 mL	<input type="radio"/> LD <input type="radio"/> RD <input type="radio"/> LT <input type="radio"/> RT <input type="radio"/> Intranasal	Admin. by <input style="width: 20px; height: 20px;" type="text"/>
DOSE # <input type="radio"/> 1 <input type="radio"/> 2	Lot Number <input style="width: 20px; height: 20px;" type="text"/>			

Date Administered (ex. 10/30/2014) <input style="width: 15px; height: 20px;" type="text"/> / <input style="width: 15px; height: 20px;" type="text"/> / <input style="width: 15px; height: 20px;" type="text"/>	<p>* REMINDER</p> <p>LAIV Is Only For Healthy Clients 2 Thru 49 Years Of Age, Who Are NOT Pregnant</p>
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