

Flu Vaccination Consent Form 2012 - 2013

Last Name										First Name										MI	
Home Address (House Number And Street Name)										Apt. Number											
City										ZIP Code					Gender: <input type="radio"/> Male <input type="radio"/> Female						
Area Code					Phone Number					Date Of Birth		(example 05/18/1980)									
Mother's First Name					Month		Day		Year												
Race / Ethnicity Choose One										<input type="radio"/> Asian <input type="radio"/> Black / African American <input type="radio"/> Hispanic / Latino <input type="radio"/> White <input type="radio"/> Other <input type="radio"/> Native Hawaiian / Pacific Islander <input type="radio"/> American Indian / Alaskan Native <input type="radio"/> Multi - Race											
1) Do you have a fever or are you sick today?										<input type="radio"/> Yes					<input type="radio"/> No						
2) Are you pregnant or do you think you may be pregnant?										<input type="radio"/> Yes					<input type="radio"/> No						
3) Have you had a serious reaction to flu vaccine requiring medical help?										<input type="radio"/> Yes					<input type="radio"/> No						
I CONSENT TO THE VACCINATION PROVIDED.										If under 18 years of age, PRINT name of parent or legal guardian											
Signature																					
STOP - DO NOT WRITE BELOW THIS LINE										SCREENER INITIALS											
4) REQUIRED: CAIR disclosure form reviewed with client?										<input type="radio"/> Yes											
5) Do you have a severe allergy to eggs?										[If YES, See Egg Allergy Guidelines]					<input type="radio"/> Yes <input type="radio"/> No						
6) Do you have an allergy to thimerosal?										<input type="radio"/> Yes <input type="radio"/> No											
7) Do you have an allergy to latex?										[If YES, Do NOT Administer GSK - Fluarix]					<input type="radio"/> Yes <input type="radio"/> No						
8) Have you ever had Guillain-Barré Syndrome (GBS)?										<input type="radio"/> Yes <input type="radio"/> No											
9) Have you received any of these vaccines in the last 4 weeks?										[MMR, Varicella, LAIV, Shingles]					<input type="radio"/> Yes <input type="radio"/> No						
10) Do you have any of the following medical conditions?										[If YES, Administer TIV ONLY]					<input type="radio"/> Yes <input type="radio"/> 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)																					
11) Is the person to be vaccinated between 2-49 years old? (Verify Age) *										[If NO, Administer TIV]					<input type="radio"/> Yes <input type="radio"/> No						
If the vaccination is for a child, ask these questions:										[If YES to either, Administer TIV ONLY]											
12) If child is < 5 years, have they been diagnosed with wheezing in the last 12 months?										<input type="radio"/> Yes <input type="radio"/> No					<input type="radio"/> N/A						
13) Is child taking long term medicine therapy containing ASPIRIN?										<input type="radio"/> Yes <input type="radio"/> No					<input type="radio"/> N/A						
14) For persons under 19 years, select VFC eligibility. (choose one)										<input type="radio"/> Uninsured <input type="radio"/> Medi-Cal / CHDP <input type="radio"/> American Indian / Alaskan Native <input type="radio"/> Not VFC eligible											
Flu Vaccine		VIS 07/02/2012		Manufacturer and Lot Number						Dosage		Site		Admin. Initials							
<input type="radio"/> INACTIVATED Flu Shot <input type="radio"/> LIVE Nasal Spray		DOSE # <input type="radio"/> 1 <input type="radio"/> 2		Manufacturer <input type="radio"/> SP <input type="radio"/> NOV <input type="radio"/> MI Lot Number		<input type="radio"/> 0.10 mL <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		<input type="text"/> <input type="text"/>											
Date Administered (ex. 10/30/2012)				* REMINDER LAIV Is Only For Healthy Clients 2 Thru 49 Years Of Age, Who Are NOT Pregnant																	
<input type="text"/> Month / <input type="text"/> Day / <input type="text"/> Year																					
Language Interpreter Signature:						Nurse Instructor Signature:															
English																					