Infant/Child/Teen Flu Vaccine Consent Form

Georgia Department of Public Health
Coastal Health District

VHN Code:

Scan for flu shot info sheet -->

Scan for flu intranasal vaccine info sheet -->

Section 1: Information About the Person Who Will Receive Vaccine (please print)

FIRST NAME	MIDDLE	LAST NAME	MAIDEN NAME OF PATIENT'S MOTHER
DATE OF BIRTH (mm/dd/yyyy)	**AGE**	**GENDER (*Please circle*)** Male Female	**SOCIAL SECURITY NUMBER**

ETHNICITY *(Please Check)*

Hispanic/Latino ☐ **Yes** ☐ **No**

RACE *(Please Check)*

☐ African American/Black ☐ White ☐ Hispanic or Latino American ☐ American Indian
☐ Asian ☐ Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Other

HOME ADDRESS **PHONE NUMBER**

CITY **STATE** **ZIP CODE**

INSURANCE INFORMATION

☐ **No Insurance** ☐ **Insurance**

Please attach a copy of the insurance card to this form.

Name of Policy Holder/Name on ID Card: _____

Member ID# _____ **Group#** _____

Section 2: Medical Information – The following questions will help us to determine if your child can receive the vaccine.

Please circle Yes, No, or I Don't Know (IDK) for every question.

1. Is the child sick today?	Yes	No	IDK
2. Does the child have allergies to medicine, food, a vaccine component, or latex?	Yes	No	IDK
3. Has the child had a serious reaction to a vaccine in the past?	Yes	No	IDK
4. Does the child have a long-term health problem with heart, lung (including asthma), kidney, liver, nervous system, or metabolic disease (e.g., diabetes), a blood disorder, no spleen, a cochlear implant, or a spinal fluid leak? Are they taking regular aspirin or salicylate medication?	Yes	No	IDK
5. For children age 2 through 4 years: Has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	Yes	No	IDK
6. For babies: Have you ever been told the child had intussusception?	Yes	No	IDK
7. Has the child, a sibling, or a parent had a seizure; has the child had a brain or other nervous system problem?	Yes	No	IDK
8. Has the child ever been diagnosed with a heart condition (myocarditis or pericarditis) or have they had Multisystem Inflammatory Syndrome (MIS-C) after an infection with the virus that causes COVID-19?	Yes	No	IDK
9. Does the child have an immune-system problem such as cancer, leukemia, HIV/AIDS?	Yes	No	IDK
10. In the past 6 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs to treat rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	Yes	No	IDK
11. Does the child's parent or sibling have an immune system problem?	Yes	No	IDK
12. In the past year, has the child received immune (gamma) globulin, blood/blood products, or an antiviral drug?	Yes	No	IDK
13. Is the child/teen pregnant?	Yes	No	IDK
14. Has the child received vaccinations in the past 4 weeks?	Yes	No	IDK
15. Has the child ever felt dizzy or faint before, during, or after a shot?	Yes	No	IDK

Section 3: Consent to vaccinate:

CONSENT TO RECEIVE VACCINE

By signing below, I acknowledge that the medical information provided above is correct. I have been given a copy of and/or scanned to view the VACCINE INFORMATION STATEMENT. I have had a chance to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the vaccine.

Signature of Patient: _____ **Date:** _____

FOR CLINIC USE ONLY

Record of Immunization

VACCINE	MFR.	LOT #	EXP.	DOSAGE	ROUTE	SITE	VIS	NURSE

Nurse Signature: _____ **Date:** _____ **Entry Clerk Initial:** _____ **Date:** _____

Date of Vaccination: _____

PUBLIC $PRIVATE$