Cedar County
Public Health
400 Cedar St. Tipton, IA
(563) 886-2226

OFFICE USE ONLY	Initials	Date
Scanned		
Entered In IRIS		
Billed		
Payment Received		

CHILD 2015/2016 Influenza Vaccine Consent Form & Administration Record

PATIENT INFORMATION

NAME: (Last) (First) (MI)		DATE OF BIRTH:	AGE:
ADDRESS: BOX#:		GENDER: (circle one) Male Female	
CITY: STATE: ZIP:		PHONE NUMBER:	
CHILD'S PHYSICIAN:		CLINIC:	

PAYMENT INFORMATION

CHECK ONE	PAYMENT		AMOUNT	IDENTIFICATION NUMBER
	Private Pay FluMist	Cash/Check	$30	
	Private Pay Injection	Cash/Check	$25	
	Uninsured		$0	
	Insurance Doesn't Cover Vaccine		$0	
	Medicaid / Meridian		$0	

THIS SECTION FOR OFFICE USE ONLY

	Left Arm
	Right Arm
	Left Thigh
	Right Thigh
	Intranasal

First Dose Sticker

☐ I have screened this patient for contraindications

Nurse's Signature: Date:

	Left Arm
	Right Arm
	Left Thigh
	Right Thigh
	Intranasal

Second Dose Sticker (if necessary)

☐ I have screened this patient for contraindications

Nurse's Signature: Date:

PLEASE COMPLETE REVERSE SIDE ➡

PLEASE ANSWER EACH QUESTION

Please check the appropriate box	YES	NO
1. Has the child ever had a severe reaction to a previous dose of flu vaccine?		
2. Does the child have a severe allergy to any components of the flu vaccine? (examples: eggs, gelatin or Gentamicin Sulfate)		
3. Does the child currently have a moderate or severe acute illness?		
4. Has the child ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks of receiving a dose of influenza vaccine?		

Answer the following questions if your child is 2-18 years old & would like the FluMist vaccine.

	YES	NO
1. Is the child under 2 years of age?		
2. Is the child pregnant or could they become pregnant within the next month?		
3. Is the child receiving aspirin or aspirin-containing products?		
4. Does the child have asthma or has the child had a wheezing episode within the last 12 months?		
5. Has the child received an MMR, chickenpox or flu nasal spray vaccine within the past 28 days?		
6. Does the child have a weak immune system? (examples: HIV/AIDS, cancer, meds used to treat cancer, steroids)		
7. Does the child have close contact with someone who has a weakened immune system?		
8. Has the child taken influenza antiviral medication within the previous 48 hours?		
9. Does the child have a long-term health problem related to heart disease, lung disease, kidney disease, neurologic disease, liver disease, metabolic disease (e.g. diabetes), anemia or another blood disorder?		

Complete for children LESS than 9 years old

If you answer "yes", child will need only one dose of the influenza vaccine this season.

	Unsure	YES	NO
1. Has this child received at least 2 doses of influenza vaccine previously?			

PLEASE READ, SIGN, AND DATE

Consent for Vaccination

I have read or had explained to me the Vaccine Information Statement for the 2015/2016 influenza vaccine (8/7/2015) and understand the risks and benefits. I understand that if my child is under the age of 9, he/she may require a second dose of this vaccine. I give consent to Cedar County Public Health to vaccinate the person named above and record this vaccination in the state's immunization registry (IRIS).

If eligible for Medicare or Medicaid benefits, I certify that the information I provided for payment is correct. I authorize release of all records required to act on this request. I authorize Medicare or Medicaid to make payments directly to the Cedar County Public Health Nursing Service.

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Signature Of Parent/Guardian Date