Premise Health

Pediatric Inactivated Influenza Vaccine Consent & Administration
(6 months – 17 years of age)

Name (Print) _____ Date of Birth: _____/_____/_____ Phone No. _____

_____
Street Address City State Zip Code

Employer _____ Employee's Name _____

Insurance plan/payor (if known) _____

The influenza vaccine is prepared using a combination of strains of both the influenza A and influenza B viruses based upon the recommendations of the Centers for Disease Control and Prevention (CDC) and the Advisory Council on Immunization Practices (ACIP). This vaccine is prepared using an inactivated/killed form of the flu virus and it is therefore impossible for the vaccine to cause the flu. Possible side effects of the vaccine are included on the Vaccine Information Statement.

Please answer the following questions:

1. Has the child ever received the influenza vaccine? ☐ Yes ☐ No
2. Is the child allergic to any medications, latex, thimerosal, eggs or egg products? ☐ Yes ☐ No
3. Has the child ever had an allergic reaction to the flu vaccine or other vaccine? ☐ Yes ☐ No
4. Is the child currently or possibly pregnant? ☐ Yes ☐ No ☐ N/A
5. Is the child currently sick or have a fever? ☐ Yes ☐ No
6. Has the child ever had Guillain-Barré Syndrome or other neurological (nervous system) disorder? ☐ Yes ☐ No

I have read the provided influenza Vaccine Information Statement, and have had any questions answered to my satisfaction. I believe that I understand the benefits and risks of the influenza vaccine and request that the vaccine be administered to my child. I acknowledge that no guarantees or assurances have been made to me concerning the results of administration of the vaccine, and I assume all responsibility for obtaining the injection for my child. I release _____, and Premise Health and its employees from any liability for any adverse reaction to the vaccine.

I acknowledge that I have been given the opportunity to receive the Premise Health Notice of Privacy Practices ("Notice") regarding uses and disclosures of information regarding my child and his or her health ("Health Information"), and a copy of this Notice can be provided to me.

NOTE: If the child has never received a flu vaccine, it is recommended that you wait in the clinic/administration area for 15 minutes after receiving the injection. If this is the child's first flu vaccine, and you choose not to wait, please initial on the following line.

_____
Initials

Dose 1: Parent/Guardian Signature: _____ Date: _____/_____/_____

Dose 2: Parent/Guardian Signature: _____ Date: _____/_____/_____

	Dose # 1	Dose # 2 (If Needed)*
Date		
Brand Name		
Manufacturer		
Lot Number		
Expiration Date		
Dose	☐ 0.25 ml ☐ 0.5 ml	☐ 0.25 ml ☐ 0.5 ml
Injection Site	Deltoid ☐ Rt. ☐ Lt. Vastus Lateralis ☐ Rt. ☐ Lt.	Deltoid ☐ Rt. ☐ Lt. Vastus Lateralis ☐ Rt. ☐ Lt.

*A second dose in about 4 weeks is required for children <9 years old receiving influenza vaccine for the first time or for children <9 years old who were incompletely vaccinated in the previous year.

VIS, dated _____, provided and vaccine administered on _____/_____/_____ at _____:_____ a.m. / p.m. by:

_____ _____
Staff Member Printed Name Staff Member Signature