Sioux Falls School District

Influenza Vaccine Consent Form

PATIENT INFORMATION: (*Please Print*) **SCHOOL:** _____

Name: _____ ☐ Male ☐ Female Date of Birth: _____

If under 18: Mother: _____ Father: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

PLEASE CHECK ONE: (ALL CHILDREN WILL RECEIVE THE VACCINE REGARLESS OF OPTION CHECKED.)

___is enrolled in Medicaid ___does not have health insurance ___ is American Indian or Native Alaskan

___has health that does not pay for vaccines ___has private health insurance that does cover vaccines

MEDICAL INFORMATION: **PLEASE CIRCLE**

1. Do you have a history of allergy to eggs or egg products? ○YES ○NO
2. Do you feel sick today or are you running a fever? ○YES ○NO
3. Have you ever had a serious reaction to the flu vaccine? ○YES ○NO
4. Have you ever had Guillain-Barré Syndrome? ○YES ○NO
5. Do you have an allergy to latex? ○YES ○NO

NEVER HAD FLU SHOT ☐

I understand the benefits and risks of the influenza vaccine and request that it be given to me or to the person named above for whom I am authorized to make this request. I have been provided a copy of the Influenza Vaccine Information Sheet (published 2015) and am aware of any possible side effects.

I also acknowledge that my private health information will only be shared with others in the interest of treatment, payment, or other necessary healthcare operations; and by signing below; I accept the privacy act policies of this facility.

According to SD law§ 34-22-12.5 we must inform you that record of this flu shot will be entered onto the State immunization registry and may be shared. If you do not wish for your child's records to be entered on the State immunization registry please contact Health Services at 367-7926 to obtain an opt out form.

Signature of Parent or Guardian:

X _____ Date _____

For Office Use

Date of Administration: _____ VIS Given: ☒ VIS:

Site of Administration: ☐ R Deltoid ☐ L Deltoid ☐ R Thigh ☐ L Thigh

Manufacturer ☐ Sanofi ☐ Novartis ☐ Glaxo

Lot # _____

Dose: ☒ 0.5 ml

Exp. Date: _____

Administered By: _____