

2018-2019 INFLUENZA CONSENT FORM

<p>Information about person to be vaccinated (please print)</p> <p>Last Name: _____ Age: _____</p> <p>First Name: _____ Sex: ___M ___F</p> <p>Date of Birth: _____ Phone # _____</p> <p>Address _____</p> <p>City _____ Zip _____</p> <p>For child - Please Print</p> <p>Parent's Name: _____</p> <p>For child being vaccinated at school based clinic</p> <p>Grade _____ School _____</p>	<p style="text-align: center;"><u>for children: office use only</u></p> <p style="text-align: right;">Child needs second dose _____</p> <p style="text-align: right;">Assess if child needs second dose _____</p> <p>Clinic :</p>
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The South Dakota Immunization Information System (SDIIS) is an automated system to document vaccinations given in South Dakota. SDIIS will give parents access to their child's immunization record from any participating South Dakota provider. SDIIS also allows providers to send reminder notices regarding needed immunizations. Health care providers, health care facilities, federal or state agencies, welfare agencies, school or family day care facilities may have access to this information in accordance with applicable HIPAA Privacy Act standards and requirements*. Immunization records remain confidential, and any person who fails to protect the information is guilty of a Class 1 misdemeanor. If you choose NOT to have you/your child's immunization record shared with other providers, you may request a refusal form.

INSURANCE COVERAGE

_____ State of SD Health Insurance Plan NUMBER: _____	_____ American Indian or Alaskan Native
_____ Enrolled in Medicaid MUST ATTACH COPY OF CARD	_____ Health insurance DOES NOT pay for vaccines
_____ No health insurance	MUST ATTACH COPY OF CARD
_____ Insurance MUST ATTACH COPY OF CARD	

For Dependent: Name of policy holder _____ **Date of Birth** _____ **Relationship** _____

Please answer the following questions for the person to be vaccinated.	Yes	No	Don't Know
1) Is the person sick today?	_____	_____	_____
2) Does the person have an allergy to eggs or to a component of the vaccine?	_____	_____	_____
3) Has the person ever had a serious reaction to influenza vaccine in the past?	_____	_____	_____
4) Has the person ever had Guillain-Barré syndrome?	_____	_____	_____

I have been provided a copy of and have read or have had explained to me the information about influenza and the vaccine listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

If covered by private insurance, I authorize SDDOH to release medical information necessary to determine benefits payable for this service. I understand I am financially responsible regardless of insurance coverage.

Signature _____ **Date** _____

(Parent or guardian if minor)

For child being vaccinated at a school based clinic

If you are completing this form for a child to be vaccinated at school and you will not be accompanying him/her, please provide a phone number where you can be reached on the day of the clinic _____

(phone)

for office use only

INFLUENZA	Type	Date/Time	Vaccine Manufacturer (Circle)	Vaccine Lot number	Route	Site (Circle)	Date of VIS Publication	Signature of person administering vaccine
	IIV4		Sanofi Pasteur 0.25ml Sanofi Pasteur 0.5ml GlaxoSmithKline 0.5ml		IM	L R Deltoid Thigh	8-7-2015	

Abbreviation Key: **IIV4** - Inactivated Influenza Vaccine, Quadravalent **IM** - Intramuscular **L** - Left **R** - Right