2023-2024 Inactivated Influenza Vaccination Consent Form — State Employee Clinic

1) Review the separate Vaccine Information Statement.
2) Complete and SIGN the consent form (1 form per person)
3) If an answer to any question 1 - 4 below is YES, you will be referred to your medical provider for vaccination.
4) Wear clothing that allows easy access to the upper arm (upper thigh for infants and preschoolers).

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 this information is guilty of a Class 1 misdemeanor. If you choose not to have the record of this immunization shared with other providers, you may request a refusal form.

Information about person to be vaccinated (please print)

Last Name _____ First Name _____ Sex M ____ F ____

Mailing Address _____ _____ ____ Phone _____ Date of Birth _____ Age _____

Race _____ Language_____Ethnicity: _____Hispanic or Latino _____Non Hispanic or Latino

City _____ Zip _____ (If Child) Parent's name _____

State of SD Health Plan NUMBER :_____ Group ID: _____

If a Covered Dependent: Name of Policy Holder _____

Policy Holder Date of Birth _____ Relationship _____

	Yes	No	Don't Know
1) Is the person to be vaccinated sick today? _____	____	____	____
2) Does the person have an allergy to eggs or to an ingredient 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 had access to the Vaccine Information Statement and have read or have had explained to me the information about influenza and influenza vaccine. 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.

Signature _____ **Date** _____

(Person to be vaccinated (If minor, parent or guardian signature)

If you need proof of vaccination - please bring your cell phone to take a picture of the consent form after vaccination.

for office use only

	Type	Date/Time	Vaccine Manufacturer (Circle)	Vaccine Lot number	Dose	IM Site (Circle)	Date of VIS Publication	Full Signature of person administering vaccine
INFLUENZA	IIV4		Sanofi Pasteur GlaxoSmithKline		0.5 mL	L R Deltoid Thigh	8-6-2021	

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

Clinic

Assessment of vaccination history for child under age 9

_____ Child will need 2nd dose

_____ Additional information needed

S.D. Department of Health Notice of Privacy Practices can be viewed at: https://doh/sd/gov/documents/HIPAANotice.pdf