

# Seasonal Flu Vaccine Screening / Consent Form



The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Patient's First Name: _____	Patient's Last Name: _____	Patient's Date of Birth: ____/____/____
Street Address _____	City: _____	Zip Code: _____
Phone Number: _____	Gender: _____	Patient's Age: _____
Mother's First Name: _____		
<b>Race and Ethnicity Information</b> (check all that apply)		
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> White
<input type="checkbox"/> Other _____	<input type="checkbox"/> More than One Race	

<u>Medical Information</u>			
1. Do you feel sick today or have a fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. Do you have allergies to medications, eggs, a vaccine component, or latex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. Have you ever had a serious reaction after receiving a flu vaccination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4. Have you ever had Guillain Barre Syndrome? (A severe paralytic illness also called GBS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

**VACCINE ADMINISTRATION CONSENT SIGNATURE**

I received a copy of the Influenza vaccine information statement (VIS). I read it or had it explained to me. I had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and the risks of the vaccine and request that the vaccine indicated be given to me or to the person named on the registration form for which I am authorized to make this request.

Authorized Signature:  Date: \_\_\_\_\_

(Self/Parent/Guardian)

The California Immunization Registry (CAIR) is a confidential, secure computer system supported by the California Department of Health. The system makes it easier for doctors, patients and parents to keep track of shots over a lifetime. Thousands of California doctors use CAIR. A record of the vaccine you received today will be entered in the CAIR system.  Check this box if you DO NOT want your vaccination to be shared with healthcare providers who use CAIR.

<b>FOR STAFF USE ONLY</b>			
After completion, please Fax this to <b>510-268-2333</b> or send copies to ACPHD, Attn: Leslie Greenwood, 1000 Broadway, Suite 500 – Oakland CA 94607			
Vaccine type: _____	Dose: _____	Manufacturer: _____	
Lot #: _____	Expiration Date: _____	Injection Site: _____	
Clinic/Site Name and City _____			<u>Credential:</u>
Dispensing Health Care Provider's Name and Signature:		MD RN LVN NP/PA Paramedic	
Name: _____	Signature: _____	DATE: _____	