TALBOT COUNTY HEALTH DEPARTMENT

FLU SHOT - CHILDHOOD CONSENT & ADMINISTRATION RECORD

******** PLEASE PRINT INFORMATION ABOUT THE PERSON TO RECEIVE VACCINE **********

NAME: Last First Middle Initial		Birth Date (mm/dd/yy)	AGE:
ADDRESS: Number & Street (Apt #)	City	County	State	Zip
SEX: M / F	Daytime Phone #: ______-______-__________	Name of Parent/Guardian	School/Grade/Teacher _____/_____/__________

<u>For children under 9 years of age</u>:
Has your child received <u>two or more</u> total doses of seasonal flu vaccine before July 1, 2018?
Y____ N____ Don't Know ____

************** PLEASE READ AND SIGN CONSENT ON THE LINE BELOW.******************

"I have read or had explained to me the information in the Vaccine Information Statement(s) (VIS) for influenza. I have had a chance to ask questions. I understand the benefits and risks of the vaccine(s). I authorize the flu vaccine be given to the above named person (includes 2nd dose if needed).
"I have been given or offered a copy of the Notice of Privacy Policies (HIPAA) form."

X__________________________________ Relationship: ________________Today's Date: ______________
(Signature of person receiving or consenting to the vaccination)

****************** PLEASE CHECK YES OR NO FOR EACH QUESTION. ******	YES	NO
1. Does your child have a severe allergy to eggs or egg products?		
2. Does your child have an allergy to gentamicin, neomycin, polymicin or gelatin?		
3. Has your child ever had a SERIOUS REACTION in the past after receiving a vaccine? Describe the reaction: ______________________________		
4. Has your child ever had Guillain – Barre Syndrome (a type of temporary muscle weakness or paralysis) within 6 weeks after receiving vaccine in the past?		
5. Has your child received any type of vaccine in the past 4 weeks? Vaccine name: ______________________ Date given:______________		
6. Does your child have diabetes or other metabolic disorder, or diseases of the lungs, heart, kidneys, liver, blood or nervous system?		
7. Does your child have ASTHMA OR HAD ANY WHEEZING DURING THE PAST 12 MONTHS?		
8. Does your child take aspirin or medicine containing aspirin every day?		
9. Does your child have a WEAK IMMUNE SYSTEM (from cancer, HIV, or medicines containing steroids or to treat cancer)?		
10. Does your child have close contact with a person with a weakened immune system AND who requires isolation or a protective environment?		
11. Has your child taken any steroid medication in the last 4 weeks?		

12. List all your child's allergies: ____
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IF YOU ANSWERED YES TO ANY OF THE QUESTIONS, YOUR CHILD'S SCHOOL NURSE WILL CALL YOU TO DISCUSS YOUR ANSWERS.

Who is your child's Doctor?

Vaccine given:	INFLUENZA
Date of VIS:	08/07/15
Route of Administration: (Circle one)	IM: LA RA LL RL OTHER: ________________________
Vaccine Manufacturer: (Circle one)	Sanofi Pasteur Novartis GSK Sequirs
FIRST DOSE	
Vaccine Lot #/Expiration date:	Place label here. First Dose
Today's Date:	First dose administered by:
SECOND DOSE********************************	
Vaccine Lot#/Expiration date:	Place label here. Second Dose (if applicable)
Today's Date:	Second dose administered by: