POD 2018-2019 INFLUENZA CONSENT FORM POD

Information about person to be vaccinated (please print)

Last Name:_____ Age: _____

First Name: _____ Sex: ___M ___F

Date of Birth:_____ Phone # _____

Address_____

City _____ Zip _____

For child - Please Print

Parent's Name:_____

For child being vaccinated at school based clinic

Grade _____ School _____

for children: office use only

Child needs second dose _____

Assess if child needs second dose _____

Clinic : Roberts County POD

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.

VFC Status (Complete for children only)

_____ Enrolled in Medicaid
_____ No health insurance
_____ Insurance
_____ American Indian or Alaskan Native
_____ Health insurance DOES NOT pay for vaccines
_____ Not VFC Eligible

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.

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

	Type	Date/Time	Vaccine Manufacturer (Circle)	Vaccine Lot number	Route	Site (Circle)	Date of VIS Publication	Signature of person administering vaccine
INFLUENZA	**IIV4**		Fluarix by GlaxoSmithKline 0.5ml FluLaval by GlaxoSmithKline 0.5ml		IM	L R Deltoid Thigh	08/07/15	

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

***** If you would like to review the Notice of Privacy Practices, Version I dated 04/14/2003 from the South Dakota Department of Health please refer to website: http://doh.sd.gov/documents/HIPAANotice.pdf

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