Annual Influenza Vaccine Consent Form

MRN: _____

Section 1: Information to Receive Vaccine (Please print)

NAME (Last, First, MI)		DATE OF BIRTH	AGE / GENDER
LEGAL GUARDIAN'S NAME (if applicable) (Last, First, MI)		PHONE # (of Guardian)	STUDENT GRADE (if applicable)
ADDRESS	CITY	STATE	ZIP
DOCTOR'S NAME (First, Last)		DOCTOR'S ADDRESS / PHONE #	
INSURANCE COMPANY	POLICY HOLDER NAME / DATE OF BIRTH	INSURANCE ADDRESS / PHONE #	
ID #			
Please bill my insurance ☐	I have Medicaid or MC+ (VFC) ☐	I have no insurance (VFC) ☐	My plan does not cover immunizations (VFC) ☐	I am Native American / Alaskan native (VFC) ☐

- **Copy of insurance card must be attached.**

Section 2: Screening for Vaccine Eligibility

Have you been vaccinated with the seasonal influenza vaccine after July 1, 2019? ☐ YES ☐ NO

Have you ever had a serious reaction to a previous dose of flu vaccine in the past? ☐ YES ☐ NO

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:

I have read or had explained to me the Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

_____I GIVE CONSENT for my child named at the top of this form to be vaccinated with the Influenza shot.

_____I DO NOT GIVE CONSENT for my child named at the top of this form to be vaccinated with this vaccine.

SIGNATURE OF PATIENT: _____ DATE: _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN: _____ DATE: _____

Section 4: Vaccination Record (FOR OFFICE USE ONLY)

DOS: _____ ☐ Right Deltoid

Provider: _____ ☐ Left Deltoid

(Place Vaccine Sticker Here)