Cedar County Public Health

400 Cedar St. Tipton, IA (563) 886-2226

OFFICE USE ONLY	Initials	Date
Scanned		
Entered In IRIS		
Billed		
Payment Received		

CHILD 2016/2017 Influenza Vaccine Consent Form

CHILD'S NAME: (Last) (First) (MI)	DATE OF BIRTH:	AGE:
ADDRESS: BOX#:	GENDER: (circle one) Male Female	
CITY: STATE: ZIP:	PHONE NUMBER:	
CHILD'S CLINIC (circle one): Genesis-Durant Mercy-Tipton Mercy-West Branch Unity Point-Clarence Unity Point-Tipton Other:		

PLEASE CHECK THE APPROPRIATE BOX	YES	NO
1. Has the child ever had a severe reaction to a previous dose of flu vaccine?		
2. Does the child have a severe allergy to any components of the flu vaccine? (eggs, gelatin, thimerosal, latex)		
3. Is the child sick with a fever today?		
4. Has the child ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness)?		

COMPLETE FOR CHILDREN LESS THAN 9 YEARS OLD	Unsure	YES	NO
1. Has this child received at least 2 doses of influenza vaccine previously? If you answer yes, child will need only one dose of the influenza vaccine this season.			

CONSENT FOR VACCINATION

- The Vaccine Information Statement for the 2016/17 influenza vaccine has been made available. I understand the risks & benefits.
- I give consent to Cedar County Public Health to vaccinate the person named above with the recommended vaccine for his/her age and to record the vaccination in the state immunization registry (IRIS).
- I understand that if my child is under the age of 9, he/she may require a second dose of this vaccine.
- I certify that the information I provided for payment is correct. I authorize release of all records required to act on this request. I authorize Medicare or Medicaid to make payments directly to the Cedar County Public Health.

Signature of Parent/Guardian: Date:

CHECK ONE	PAYMENT		AMOUNT	IDENTIFICATION NUMBER
	Private Pay	Cash/Check	$25	
	Uninsured		0	
	Insurance Doesn't Cover Vaccinations		0	
	Medicaid (United, Amerigroup, AmeriHealth Caritas)		0	

THIS SECTION FOR OFFICE USE ONLY

	Left Arm		Right Arm		Left Thigh		Right Thigh

☐ I have screened this patient for contraindications

Nurse's Signature: Date:

	Left Arm		Right Arm		Left Thigh		Right Thigh

Nurse's Signature: Date: