2023-2024 INACTIVATED INFLUENZA CONSENT FORM

Information about person to be vaccinated (please print)

Last Name:_____ Age:___ Sex: ___M ___F

First Name:_____ Date of Birth:_____

Race:_____ Language:_____

Ethnicity:_____Hispanic or Latino _____Non Hispanic or Latino

Mailing Address:_____ Zip:_____

City:_____ Phone #:_____

For child - Please Print

Parent's Name:_____

For child being vaccinated at school based clinic

Grade _____ School _____

Assessment of vaccination history for child under age 9

_____ Child will need 2nd dose

_____ Additional information needed

Clinic : Marshall County Community Health
909 Main St
Britton, SD 57430

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 the record of this immunization shared with other providers, you may request a refusal form.

INSURANCE Status

___ Insurance **(MUST ATTACH COPY OF CARD)**
___ Medicaid * **(MUST ATTACH COPY OF CARD)**
___ No Insurance *
___ Insurance that DOES NOT cover vaccines *
___ American Indian or Alaskan Native 18 yrs. and under *

* *Children age 18 and under in these categories are Vaccines for Children Program eligible*

For Dependent Covered by Private Insurance

Name of Policy Holder _____

Policy Holder Date of Birth _____

Relationship _____

Please answer the following 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 an ingredient 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 influenza vaccine. 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.

If insured, I authorize SDDOH to release medical information necessary to determine benefits payable for this service. I understand that I am financially responsible for services regardless of insurance coverage.

Signature _____ **Date** _____

Person to be vaccinated (If minor, parent or guardian)

For child being vaccinated at a school based clinic

If 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	Dose	IM Site (Circle)	Date of VIS Publication	Full Signature of person administering vaccine
INFLUENZA	IIV		Sanofi Pasteur GlaxoSmithKline		0.5 mL	L R Deltoid Thigh	8-06-2021	

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

S.D. Department of Health Notice of Privacy Practices can be viewed at https://doh.sd.gov/documents/HIPAANotice.pdf Rev. 08/2023