Garretson School District

Influenza Vaccination Consent Form

PATIENT INFORMATION: *(please print)*

Name: _____ Date of Birth:_____ Male_____Female_____

If under 18: Mother:_____ Father:_____

Address: _____ Phone Number:_____

City:_____ State: _____ Zip:_____

PLEASE CHECK ONE: (ALL CHILDREN WILL RECEIVE THE VACCINE REGARDLESS OF OPTION CHECKED)

_____is enrolled in Medicaid _____does **not** have health insurance _____is American Indian or Native Alaskan

_____has private health insurance that **does not** pay for vaccines _____has private health insurance that **does** cover vaccines

Medical Information:		**Please Circle:**	
1.	Do you have a history of allergy to eggs or egg products?	YES	NO
2.	Do you feel sick today or are you running a fever?	YES	NO
3.	Have you ever had a serious reaction to the flu vaccine?	YES	NO
4.	Have you ever had Guillain-Barre Syndrome?	YES	NO
5.	Do you have an allergy to latex?	YES	NO

I understand the benefits and risks of the influenza vaccine and request that it be given to me or to the person named above for whom I am authorized to make this request. I have been provided a copy of the Influenza Vaccine Information Sheet (published 2021) and am aware of any possible side effects.

I also acknowledge that my private health information will only be shared with others in the interest of treatment, payment, or other necessary healthcare operations; and by signing below I accept the privacy act policies of this facility.

According to SD law 34-22-12.5 we must inform you that record of this flu shot will be entered into the state immunization registry and may be shared. If you do not wish for your child's records to be entered on the state immunization registry, please contact Health Services at (605) 367-7926 to obtain an opt out form.

Signature of Patient (if over age 18) or Parent/Guardian (if under age 18):

X_____ Date_____

For Office Use Only

Date of Administration (circle one): 10/18/2023 10/25/2023 VIS Given: Yes_____ (**VIS: 8/6/2021)**

Site of Administration: _____Right Deltoid _____Left Deltoid _____Right Thigh _____Left Thigh

Manufacturer:

Lot #:

Exp. Date:

Administered By: Elizabeth ("Betsy") Howe, RN