TALBOT COUNTY
HEALTH DEPARTMENT

Fahmi Fahmi, Health Officer
510 Cadmus Lane, Easton, MD 21601 • 410-819-5600• talbothealth.org

Influenza (Flu) Vaccination Consent Form MInor

2025–2026 Flu Season **Section 1: Child's Information**

Child's Full Name: _____

Date of Birth (MM/DD/YYYY): _____ **Age:** _____

Sex: ☐ Male ☐ Female ☐ Other

Parent/Legal Guardian's Full Name: _____

Relationship to Child: _____

Primary Contact Phone Number: _____

Email Address: _____

Health Screening Questions (Please check YES or NO)

1. Are you feeling sick today? ☐ Yes ☐ No

2. Do you have allergies to eggs, latex, or any vaccine component? ☐ Yes ☐ No

3. Have you ever had a severe allergic reaction to a flu shot? ☐ Yes ☐ No

4. Have you ever had Guillain-Barré Syndrome (GBS)? ☐ Yes ☐ No

5. Do you have a weakened immune system (from illness, medication, or other causes)? ☐ Yes ☐ No

6. For women: Are you pregnant or breastfeeding? ☐ Yes ☐ No

By signing below, I confirm the following:

1. I have read this form and the Vaccine Information Statement and have had a chance to ask questions.
2. I voluntarily consent for the influenza vaccine to be administered to the child named above.

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3. I authorize this healthcare provider to release any medical or other information necessary to process a claim for payment to Medicare, Medicaid, or other third-party payors.
4. I authorize this information to be shared with my state/local health department's immunization registry for public health purposes.
5. I acknowledge that I have been given a copy of, or an opportunity to read, the current CDC Vaccine Information Statement (VIS) for the Inactivated Influenza Vaccine. It

Signature: _____

Printed Name: _____

Date: _____

FOR ADMINISTRATIVE USE ONLY

Vaccine Type: ☐ Inactivated Influenza Vaccine (IIV) - Shot ☐ Live Attenuated Influenza

Vaccine Name/Manufacturer: _____

Lot Number: _____ **Expiration Date:** _____

Site of Administration: ☐ Right Deltoid ☐ Left Deltoid ☐ Right Thigh ☐ Left Thigh

Date Vaccine Administered: _____

Administered by (Signature): _____

Administered by (Printed Name & Title): _____

Clinic/Site Name: _____