NEVADA COUNTY PUBLIC HEALTH DEPARTMENT

FLU CONSENT FORM

Manufacturer: _____

Lot # & Expiration: _____

Patient Name: _____ Gender: _____ DOB: _____ (MM / DD / YY) AGE: _____

Address: _____ Telephone #: _____

_____ Zip: _____ Mother's First Name: _____

Nevada County Public Health Department requires that we collect the following demographic data. This information is confidential and allows us to provide quality services. **THE INFORMATION BELOW IS FOR THE INDIVIDUAL RECEIVING IMMUNIZATION(S).**

Choose one:

Ethnic Group

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown

Choose one or more:

Race

- ☐ Alaska Native or American Indian
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White or Hispanic
- ☐ More than One Race
- ☐ Other Race
- ☐ Declined to State

Choose one:

Language

- ☐ English
- ☐ Spanish
- ☐ Indian (includes Hindi & Tamil)
- ☐ Other

VFC Eligibility (Children 18 years and under)

The following statements will help us determine if your child may receive immunizations through the Vaccine For Children (VFC) program.
Please check applicable box below for child receiving immunization:

- ☐ 1. is Medi-Cal or Child Health & Disability Program (CHDP) eligible.
- ☐ 2. is Uninsured (does not have private health insurance).
- ☐ 3. is an American Indian or Alaskan Native.

Does the patient have Medi-Cal (Adults 19 years and older)? ☐**Yes** ☐**No**

I have read or have had explained to me the information on this form about influenza and influenza vaccine (VIS). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and request that it be given to me or to the person named below for whom I am authorized to make this request. I understand that Nevada County Public Health Department enters immunization information into the California Immunization Registry (CAIR). I acknowledge that I have received a copy of the Nevada County Notice of Privacy Practices. I hereby authorize the Nevada County Public Health Department, to release this information to my designated medical provider(s), school(s), and upon my verbal request, to myself.

Signature: _____ **Date:** _____

Patient (Parent or Guardian if under 18 years of age)

Screening Questionnaire for Vaccine Eligibility

Inactivated Flu Vaccine The following questions will help us determine if you can be vaccinated for the seasonal flu today. Your answers to the following questions will help us determine which vaccine is right for you.	**Yes**	**No**	**Don't Know**
Person receiving vaccine:			
1. Are you feeling sick today?			
2. Are you pregnant or could you become pregnant within the next month?			
3. Have you had the flu vaccine before?			
4. Have you had a serious reaction to the influenza vaccine in the past?			
5. Are you allergic to egg, egg products, thimerosal or latex? Circle the allergy(ies) that apply.			
6. Have you ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness)?			
7. Do you need documentation of vaccination? Please ask for a **Blue Card**.			

NURSE USE ONLY Site of injection: ☐ left deltoid ☐ left thigh ☐ right deltoid ☐ right thigh

RN Signature: _____ Date _____

VIS 8/15/2019