2010-2011 SEASONAL INFLUENZA CONSENT FORM

Information about person to be vaccinated **(please print)**

Last Name:_____ Age: _____

First Name: _____

Date of Birth:_____ Phone # _____

Address_____

City _____ Zip _____

For child

Parent's Name:_____

For child being vaccinated at school based clinic

Grade _____ School _____

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Child needs second dose _____

Assess if child needs second dose _____

Clinic :

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. Immunization records remain confidential, and any person who fails to protect the confidentiality of this information is guilty of a Class 1 misdemeanor. If you choose NOT to have your/your child's immunization record shared with other providers you may request a refusal form.

For child being vaccinated - check any that apply

_____ Enrolled in Medicaid Please provide Medicaid #_____

_____ Does not have health insurance

_____ American Indian or Alaskan Native

_____ Health insurance that DOES NOT pay for vaccines

Please answer the following questions for the person to be vaccinated.	Yes	No	Don't Know
1) Is the person ill?	_____	_____	_____
2) Does the person have an allergy to eggs or to a component 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?	_____	_____	_____
For Children age 8 and younger			
5) Did the child receive two doses of **H1N1** vaccine in 2009-2010?	_____	_____	_____
6) If the child had **seasonal** flu vaccine for the 1st time last year, did he/she get **2** doses?	_____	_____	_____

I have been provided a copy of and have read or have had explained to me the information about influenza and the vaccine listed below. 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.

Signature _____ **Date** _____

(Parent or guardian if minor)

For child

If you are 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)

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	Type	Date/Time	Vaccine Manufacturer (Circle)	Vaccine Lot number	Route	Site (Circle)	Date of VIS Publication	Signature of person administering vaccine
INFLUENZA	TIV		Sanofi Pasteur CSL		IM	L R Deltoid Thigh	8/10/10	

NOTICE OF PRIVACY PRACTICES - STATE OF SOUTH DAKOTA DEPARTMENT OF HEALTH

If you would like to review the Notice of Privacy Practices, Version I dated 04/14/2003 from the South Dakota Department of Health please refer to website: http://doh.sd.gov/PDF/HIPAANotice.pdf

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