2019-2020 INACTIVATED INFLUENZA CONSENT FORM

Information about person to be vaccinated (please print)

Last Name:_____ Age: _____

First Name: _____ Sex: ___M ___F

Date of Birth:_____ Phone # _____

Mailing Address _____

City _____ Zip _____

For child - Please Print

Parent's Name:_____

For child being vaccinated at school based clinic

Grade _____ School _____

for children: office use only

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 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 you/your child's immunization record 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 (VFC 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 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?	_____	_____	_____

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** _____

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	Signature of person administering vaccine
INFLUENZA	IIV4		Sanofi Pasteur GlaxoSmithKline		0.5 mL	L R Deltoid Thigh	8-15-2019	

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