2019-2020 LAIV4 CONSENT FORM (Live Attenuated Influenza Vaccine, quadrivalent)

Child must be VFC Eligible.

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: Parent's name _____

for 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 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.

Vaccines For Children Program Eligiblity

_____ American Indian or Alaskan Native
_____ No health insurance
_____ Medicaid (Must Provide Copy of Medicaid Card)
_____ Insurance that DOES NOT COVER vaccines

Check the appropriate answers for the person to be vaccinated. Check N/A if not applicable	**Yes**	**No**	**N/A**	**Don't Know**
1) Is the person sick today?				
2) Does the person have an allergy to eggs or to a component of influenza vaccine?				
3) Has the person ever had a serious reaction to influenza vaccine in the past?				
4) Is the person younger than age 2 years or older than age 49 years?				
5) Does the person have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease(e.g. diabetes),or anemia or another blood disorder?				
6) If the person is a child 2 years through 4 years, in the past 12 months has a healthcare provider told you the child had wheezing or asthma?				
7) Does the person have cancer, leukemia, HIV/AIDS, or any another immune system problem; or, in the past 3 months, have they taken medications that affect the immune system, such as prednisone, other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis or anticancer drugs; or have they had radiation treatments?				
8) Is the person receiving influenza antiviral medications?				
9) Is the person aged 2 through 17 years and receiving aspirin therapy or aspirin-containing therapy?				
10) Is the person pregnant or could she become pregnant within the next month?				
11) Has the person ever had Guillain-Barre syndrome?				
12) Does the person live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?				
13) Has the person received any other vaccinations in the past 4 weeks?				

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)

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Date/Time	Vaccine/ manufacturer	Lot number	Route	Date of VIS	Signature of Vaccinator
	LAIV4/MedImmune		Intranasal	08/15/19	

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