

2020-2021 State Employee Influenza Clinic

- 1) Review the separate Vaccine Information Statement.
- 2) **Fully complete and sign** this form BEFORE arriving. (1 form per person)
- 3) Review questions 1-12 below
If an answer to questions 1, 2, or 3 is YES, you will be referred to your medical provider for vaccination.
If an answer to a question 4 thru 12 is YES, access to the clinic will be denied as a COVID-19 precaution
- 4) **Face Masks are REQUIRED.** Bring your own masks for adults and school aged children
- 5) Clinic flow will facilitate social distancing; please respect directions and signs
- 6) Wear clothing that allows easy access to the upper arm (upper thigh for infants and preschoolers)
- 7) Plan to wait 15 minutes after vaccination in the designated area.

CLINIC:

Information about person to be vaccinated (please print)

Last Name _____ First Name _____ Sex ____ M ____ F
 Date of Birth: _____ Phone # _____ Mailing Address _____
 City _____ Zip _____ (If Child) Parent's name _____

State of SD Health Plan NUMBER : _____ Group ID: _____

Two digit number on insurance card reflecting covered individual: (e.g. 01, 02.) _____

For a Dependent Covered by SD Health Plan: Name of Policy Holder _____

Policy Holder Date of Birth _____ Relationship _____

DO NOT ATTEND THE CLINIC IF any answer is YES

	Yes	No	Don't Know
1) Does the person have an allergy to eggs or to a component of the vaccine? _____	_____	_____	_____
2) Has the person ever had a serious reaction to influenza vaccine in the past? _____	_____	_____	_____
3) Has the person ever had Guillain-Barré syndrome? _____	_____	_____	_____
4) Is the person sick today? _____	_____	_____	_____
5) Fever or chills? _____	_____	_____	_____
6) A new cough, shortness of breath, or difficulty breathing? _____	_____	_____	_____
7) New headaches, new muscle or body aches, unusual fatigue? _____	_____	_____	_____
8) New loss of taste or smell? _____	_____	_____	_____
9) New sore throat? _____	_____	_____	_____
10) Nausea, vomiting, or diarrhea? _____	_____	_____	_____
11) Exposed within the last two weeks to someone positive for COVID-19? _____	_____	_____	_____
12) Positive for COVID-19 and waiting to be released from isolation? _____	_____	_____	_____

I have had access to the Vaccine Information Statement and have read or have had explained to me the information about influenza and influenza vaccine. 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 signature)

If you need proof of vaccination - please bring your cell phone to take a picture of the consent after vaccination.

for office use only

INFLUENZA	Type	Date/Time	Vaccine Manufacturer (Circle)	Vaccine Lot number	Dose	IM Site (Circle)	Date of VIS Publication	Full Signature of person administering vaccine
	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

For child under age 9: _____ **Needs 2nd Dose** _____ **Assess if child needs second dose** (8/2020)