2018-2019 INFLUENZA CONSENT FORM

Information about person to be vaccinated (please print)

Last Name:___________________________________ Age: ________

First Name: _______________________________ Sex: ___M ___F

Date of Birth:____________________ Phone # __________________

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 : Day County Community Health
711 W 1st St Ste 102
Webster, SD 57274

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 COVERAGE

_____ State of SD Health Insurance Plan **NUMBER:**_______________________________________

_____ Enrolled in Medicaid **MUST ATTACH COPY OF CARD**

_____ No health insurance

_____ Insurance **MUST ATTACH COPY OF CARD**

_____ American Indian or Alaskan Native

_____ Health insurance DOES NOT pay for vaccines **MUST ATTACH COPY OF CARD**

For Dependent: Name of policy holder ______________________________ **Date of Birth** ______________ **Relationship** ________________

Please answer the following questions 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.

If covered by private insurance, I authorize SDDOH to release medical information necessary to determine benefits payable for this service. I understand I am financially responsible regardless of insurance coverage.

Signature ____ **Date** ______________

(Parent or guardian if minor)

For child being vaccinated at a school based clinic

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)

for office use only

	Type	Date/Time	Vaccine Manufacturer (Circle)	Vaccine Lot number	Route	Site (Circle)	Date of VIS Publication	Signature of person administering vaccine
INFLUENZA	IIV4		Sanofi Pasteur 0.25ml Sanofi Pasteur 0.5ml GlaxoSmithKline 0.5ml		IM	L R Deltoid Thigh	8-7-2015	

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

***** 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/documents/HIPAANotice.pdf

Rev. 9/3/2018