Sanders County Health Department
Influenza Immunization Consent Form

Name (first & last)	**Date of Birth**	**Sex**	**Phone number**
Mailing address	**City**	**State**	**ZIP**
	For Persons Under 18 years old Parent or Guardian name (first & last)		
Medicare Card # **SSN#:**	**Health Insurance Company**		**Member ID#**
Medicare supplemental insurance **Member ID#**	**I do not have any health insurance coverage:** _____		

Veterans Insurance Benefits# (on back of card) : **SSN#**

Please complete the questions below for yourself or the person receiving the vaccine.

☐ No ☐ Yes Are you currently sick with a fever?

☐ No ☐ Yes Have you ever had a life threatening allergy to any component (or part) of the flu vaccine? If yes, please describe: _____

☐ No ☐ Yes Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving flu vaccine?

☐ No ☐ Yes Have you ever had a severe life threatening allergy to eggs or egg products?

☐ No ☐ Yes Are you currently pregnant?

☐ No ☐ Yes Are you a child or adolescent receiving long-term aspirin therapy?

☐ No ☐ Yes Have you taken an antiviral medication for the flu within the last 48 hours?

Influenza Consent

I have read, or had explained to me, the Vaccine Information Statement about the **influenza** vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the **influenza** vaccination be given to me (or the person named above for whom I am authorized to make this request.

_____

*** Signature of Recipient (Parent or Guardian)** **Date**

imMTrax Database Consent

I authorize the public health department to collect and enter my immunization records into the Department of Public Health and Human Services Immunization Information System. This is a confidential, computer system that contains immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my medical care and treatment. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department.

_____

*** Signature of Recipient (Parent or Guardian)** **Date**

TO BE COMPLETED BY NURSE

Influenza Vaccine

Administration Date: _____

Administration Site : ___Right Arm ___Left Arm ___Nasal

High Dose ___

Dosage: ___0.5 ml ___ 0.25 ml ____0.7

Lot #:_____ VIS Date: 1/31/2025

Nurse signature: _____