CHC SEK **Community Health Center of Southeast Kansas**
Pittsburg Baxter Springs Columbus Parsons Iola Coffeyville Independence

Influenza Vaccine Informed Consent

Patient's Full Name: _____ Age:____

Date of Birth: _____/ _____/ _____ Male (M) or Female (F): ___ Phone: _____

Street Address: _____ City: _____ Zip: _____

Please answer the following questions:

Questions		**Yes/ no**
1.	Are you a patient of CHC/SEK?	Y / N
2.	Have you had the flu shot or flu-mist before?	Y / N
3.	Have you ever had an allergic reaction to the flu shot?	Y / N
4.	Do you currently have a fever or illness?	Y / N
5.	Are you allergic to eggs, chicken, or chicken feathers?	Y / N
6.	Are you allergic to thimerosal or mercury?	Y / N
7.	Have you had a condition called Guillain-Barre Syndrome?	Y / N
8.	Do you have asthma or COPD?	Y / N
9.	Do you or any household members have a problem with your immune system?	Y / N
10.	Have you taken steroids(prednisone,orapred,medrol-dose pack) in the last 2 weeks?	Y / N
11.	Are you pregnant?	Y / N

FOR PATIENTS AGE 18 and UNDER -- Indicate VFC Eligibility						
___Medicaid/19 VFC	___Medicaid/21 CHIP	___Native Am/ Alaskan Native	__Underinsured*^	___Underserved**^	___No Health Insurance	___Fully Insured

*Underinsured children: insurance does not cover immunizations, are eligible through VFC program if vaccinated at a FQHC or RHC.
**Underserved children: children have insurance co-pay or deductible high enough to provide a barrier to immunizations.
^ Underserved and Underinsured children are eligible through state funded vaccine program if vaccinated at a public county health clinic.

I have been offered a copy of the Vaccine Information Statement (VIS). I have read, had explained to me, and understand the information in the VIS. I ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. If a minor, I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named above.

A copy of the notice of Privacy Practices has been made available to me.

_____ _____
Signature of Patient or Parent/Guardian Date

Updated 09/06/2016

What to do for "yes" answers:

1. document in patient electronic medical record
2. if no, and less than 9 years old, will need 2nd immunization after 30 days
3. if yes, no flu shot or mist
4. if yes, no immunization, return for immunization when well
5. if yes, advise patient of the increased risk of allergic reaction. If patient elects to receive vaccine, watch for 15 minutes after administering immunization for reaction.
6. if yes, may use flu-mist or single dose infant. NOT fluzone multi-dose
7. no flu shot or mist
8. if yes, give flu shot, NOT flu-mist
9. if yes, give inactivated flu shot, NOT flu-mist
10. if yes, no immunization today, return 2 weeks after steroids completed (for patients chronically on steroids (>2weeks), give inactivated flu shot today)
11. if yes, only give inactivated flu shot, NOT flu-mist. Can be given anytime during pregnancy

Influenza vaccine dosage, by age group

Age	Dose	No. of Doses
6-35 months	0.25mL	2*
3-8 years	0.5mL	2*
9 years through Adults	0.5 mL	1

*Two doses are recommended for children under 9 years of age who have not been previously vaccinated with influenza vaccine. The two doses should be administered at least one month apart and if possible, the second dose should be given before December

Lot #: Manufacturer: Exp: NDC:

VIS DATE: 08/07/2015

___ 0.5 ml administered to the LEFT / RIGHT deltoid/ anterolateral

___ 0.25 ml administered to the LEFT / RIGHT deltoid/anterolateral

_____Date_____

Signature & Title of Vaccine Administrator