Fergus County Nurses Office
Child and Teen Influenza Vaccine Consent Form

Child's Name:_____/_____/_____ ☐ **Male** ☐ **Female**
First M.I. Last

Date of Birth:_____/_____/_____**Age**_____**Phone**_____

Address:_____ **City:**_____**State:**_____**Zip:**_____

Mother's Name: _____ **Child's Dr.:**_____

Father's Name:_____

Primary Source of Insurance: (please check one) ☐ **Private Ins.** ☐ **HMKPlus** ☐ **HMK** ☐ **None** ☐ **Other**_____

Insurance Company Name: _____

Insurance Subscriber's Name: **Subscriber's Birth Date: / /**

Child's Relationship to Subscriber:
Self ☐ **Spouse** ☐ **Child** ☐ **Other** ☐

Subscribers S.S#:

Policy Number:_____

Group Number:_____

1. **Does the client have any special health care needs (congenital/chronic medical conditions)?** **Yes _____No_____**
2. **Is the client a woman between the ages of 15 & 19 years old?** **Yes _____No_____**
   If you answered "Yes" to question #3, is the client currently pregnant? **Yes _____No _____Unknown_____**
3. **Is the client sick today?** **Yes _____No_____**
4. **Has the client had a serious reaction after receiving any vaccine?** **Yes _____No_____**
5. **Does the child have allergies to medications, food, or any vaccine?** **Yes _____No_____**
   Explain: _____
6. **What is client's race? (please check all that apply): white _____Native American/Alaska Native _____Asian_____**
   Black/African American _____Native Hawaiian/Pacific Islander _____Other_____
7. **Is the client of Hispanic or Latino origin? Yes _____No_____**

I have read the Vaccine Information Sheet(s) and have had a chance to ask questions. The risks and benefits have been explained to me or the person named for who I am authorized to make this request. I give the consent without coercion or reservation.
I authorized my health care provider and a public health agency to collect and enter my child's immunization record into the Department of Public Health and Human Services' Immunization Information System (IIS) or imMTrax. The IIS is a confidential, computer system than 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 child's medical care and treatment. In addition, information may be released to child care facilities and schools in which my child is enrolled to comply with state immunization requirements. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department. The above information is true to the best of my knowledge. I authorize Fergus County Nurse's Office to bill my insurance and agree benefits be paid directly to the (Fergus County Nurse's Office). I understand that I am financially responsible for any balance. I also authorize (Fergus County Nurse's Office) or my Insurance Company to release any information required to process my claim(s). I also give permission to the (Fergus County Nurse's Office) to release health care information regarding any vaccinations or reactions to the Health Care Provider I have specified.

X_____ **Date:** _____
Signature of Legally Responsible Person

For Office Use Only

Date of service(s): **VIS Form: 08/07/2015**

_____ _____

P/V---Flu #1 Site: RA LA

Lot : _____ **Exp. Date:**_____

_____
RN Signature

P/V---Flu #2 Site: RA LA

Lot: _____ **Exp. Date:** _____

_____
RN Signature