

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: _____ Father's Name: _____

Child's Dr.: _____

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

Policy Number: _____

Group Number: _____

Subscribers S.S#: _____

1. Is the child sick today? Yes ___ No ___
2. Does the child have an allergy to a component of the vaccine? Yes ___ No ___
 Explain: _____
3. Has the child had a serious reaction to an influenza vaccine in the past? Yes ___ No ___
4. Has your child ever had Guillain-Barré Syndrome? Yes ___ No ___
5. Does the child have any special health care needs (congenital/chronic medical conditions)? Yes ___ No ___
6. What is the client's race? (please check all that apply):
 ___ white ___ Native American/Alaska Native ___ Asian ___ 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 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 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: 08/06/2021 |
| P/V---Flu #1 Site: RA LA | P/V---Flu #2 Site: RA LA |
| Lot : _____ Exp. Date: _____ | Lot: _____ Exp. Date: _____ |
| _____ RN Signature | _____ RN Signature |