Office Use Only: ☐VFC ☐ PRIVATE

Marquette County Health Department Seasonal Influenza Vaccine Program

Child Form (*6 months through 18 years of age)*

Legal Name:_____ Date of Birth: _____

Address:_____ City: _____ **Sex:** ☐ Male ☐ Female
Race: ☐White ☐Asian ☐Black/African American ☐Native Alaskan/American Indian
☐Native Hawaiian/Pacific Islander **Ethnicity:** ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Are you enrolled in any of the following?: (Please present your insurance card to registration)
☐ Medicaid ☐ Medicare Part B ☐ No Medical Insurance ☐ Cash/Check/Credit
☐ Insurance WITH Immunization Coverage ☐ Insurance WITHOUT Immunization Coverage
*Attach copy of insurance card or provide the following information:
Insurance Carrier Name:_____ Policy Number:_____
Card Holder's Name**:** _____ Card Holder's Date of Birth: __/__/__
Card Holder's phone number:_____Relationship to child: _____

Medical Screening Questionnaire & Consent for Vaccination

YES	NO	
		1. Have you ever had a serious reaction to a vaccine?
		2. Are you allergic to eggs, gelatin, or any antibiotics?
		3. Have you ever had Guillain-Barre syndrome (GBS)?
		4. Are you currently ill or running a fever?
For children age 2 and up:		***please answer these additional questions to determine if you can get the Flu Mist.***
		5. Do you have any long-term health problem such as heart or lung disease, kidney disease or diabetes?
		6. Do you have a low platelet count or a bleeding disorder?
		7. Do you have asthma or have you had a recent episode of wheezing in the past 12 months?
		8. Are you currently receiving aspirin therapy?
		9. Are you or do you think you may be pregnant?
		10. Have you received any vaccine within the past 30 days?
		11. Do you have cancer, leukemia, lymphoma, or any immune deficiency disease (inability to fight infection)?
		12. Are you currently receiving chemotherapy, radiation therapy or steroid therapy (prednisone or cortisone)?
		13. Do you have close contact with anyone who has a severely weakened immune system (for example, an individual who has had a bone marrow transplant and is currently in a hospital isolation room)?

"I have read or have had explained to me the information in the 2014-15 vaccine information statement (VIS). I have also had a chance to ask any questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine." *(Initial here)* _____

Marquette County Health Department has made their Privacy Act practices available to me. *(Initial here)* _____

"I authorize the release of any medical or other information with respect to this vaccine to Medicare, Medicaid or other third party payer as needed to request payment of authorized benefits to be made on my behalf to Marquette County Health Department. I acknowledge that if my insurance does not cover the cost of administering the vaccine then I will be responsible for any balance on my account for which I will receive a statement. "

_____ _____
SIGNATURE of Responsible Party **DATE**

Printed name of Responsible Party :_____

THIS SIDE OF FORM TO BE COMPLETED BY MARQUETTE COUNTY HEALTH DEPT STAFF ONLY

NURSE STAFF **Date Vaccine given: _____**

Vaccine	Manuf.	Lot #	Route	Site	Nurse Signature
FluMist (LAIV 4)	FFF Ent.		IN		
Flu Q (IIV4) 0.5mL	GSK		IM	RD LD RT LT	
Flu Q (IIV4) 0.25mL (6 mo. to 2 years)	Sanofi		IM	RD LD RT LT	

Nurse Notes: