

CHILD---INFLUENZA VACCINE RECORD OF ADMINISTRATION & RECIPIENT SIGNATURE

I have been provided a copy of, and have read or had explained to me the information in the 2015-16 Influenza Vaccine Information Sheet dated 8/7/15. I have had a chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of the influenza vaccine, and ask that the vaccine be given to my child.

PLEASE PRINT CLEARLY. (All information must be filled in completely)

(Last) (First) (Middle)

Any previous name or nickname used: _____

Parent &/or guardian information:

(Last) (First) (Middle)

Relationship to child: _____

School child attends _____

Date of Birth: _____ *Birth State* _____ *Age:* _____

Address: _____

City _____ *State* _____ *Zip Code* _____

County of Residence: _____ *Gender:* ___ male ___ female

Phone #: _____ *Alternate Phone #:* _____

Email _____

Race: (check one) ___ White ___ African American ___ American Indian ___ Alaskan Native
___ Asian/Pacific Islander ___ Multiracial ___ other ___ unknown

Physician: _____

Allergies: _____

Signature of person to receive vaccine or person authorized to give consent:

_____ *Date* _____

For Office Use Only

Clinic Location: AFF--ALC--BLC--COA--COL--DCHD--HC--LCC--LFF--SIEOC--UCB

(Lot # sticker) **Date Vaccinated:** _____

Site of Vaccination: Left Arm Right Arm Left Thigh Right Thigh

Vaccinator Signature & Title: _____

Patient name: _____

Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Children and Teens

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, a vaccine component, or latex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. If the child to be vaccinated is between the ages of 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If your child is a baby, have you ever been told he or she has had intussusception?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In the past 3 months, has the child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your child's immunization record card with you? yes no

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.