

**TALBOT COUNTY HEALTH DEPARTMENT
FLU SHOT - CHILDHOOD CONSENT & ADMINISTRATION RECORD**

******* PLEASE PRINT INFORMATION ABOUT THE PERSON TO RECEIVE VACCINE *******

NAME: Last		First	Middle Initial	Birth Date (mm/dd/yy)	AGE:	
ADDRESS: Number & Street		(Apt #)	City	County	State	Zip
SEX: M / F	Daytime Phone #: ____-____-____		Name of Parent/Guardian		School/Grade/Teacher ____/____/____	

For children under 9 years of age:

Has your child received two or more total doses of seasonal flu vaccine before July 1, 2018?

Y___ N___ Don't Know ___

******* PLEASE READ AND SIGN CONSENT ON THE LINE BELOW. *******

"I have read or had explained to me the information in the Vaccine Information Statement(s) (VIS) for influenza. I have had a chance to ask questions. I understand the benefits and risks of the vaccine(s). I authorize the flu vaccine be given to the above named person (includes 2nd dose if needed).

"I have been given or offered a copy of the Notice of Privacy Policies (HIPAA) form."

X _____ Relationship: _____ Today's Date: _____

(Signature of person receiving or consenting to the vaccination)

******* PLEASE CHECK YES OR NO FOR EACH QUESTION. ***** YES NO**

1. Does your child have a severe allergy to eggs or egg products?		
2. Does your child have an allergy to gentamicin, neomycin, polymycin or gelatin?		
3. Has your child ever had a SERIOUS REACTION in the past after receiving a vaccine? Describe the reaction: _____		
4. Has your child ever had Guillain – Barre Syndrome (a type of temporary muscle weakness or paralysis) within 6 weeks after receiving vaccine in the past?		
5. Has your child received any type of vaccine in the past 4 weeks? Vaccine name: _____ Date given: _____		
6. Does your child have diabetes or other metabolic disorder, or diseases of the lungs, heart, kidneys, liver, blood or nervous system?		
7. Does your child have ASTHMA OR HAD ANY WHEEZING DURING THE PAST 12 MONTHS?		
8. Does your child take aspirin or medicine containing aspirin every day?		
9. Does your child have a WEAK IMMUNE SYSTEM (from cancer, HIV, or medicines containing steroids or to treat cancer)?		
10. Does your child have close contact with a person with a weakened immune system AND who requires isolation or a protective environment?		
11. Has your child taken any steroid medication in the last 4 weeks?		
12. List all your child's allergies: _____		

**IF YOU ANSWERED YES TO ANY OF THE QUESTIONS, YOUR CHILD'S SCHOOL NURSE
WILL CALL YOU TO DISCUSS YOUR ANSWERS.**

Who is your child's Doctor? _____

Vaccine given:	INFLUENZA
Date of VIS:	08/07/15
Route of Administration: (Circle one)	IM: LA RA LL RL OTHER: _____
Vaccine Manufacturer: (Circle one)	Sanofi Pasteur Novartis GSK Sequrs
*****FIRST DOSE*****	
Vaccine Lot #/Expiration date:	Place label here. First Dose
Today's Date:	First dose administered by:
*****SECOND DOSE*****	
Vaccine Lot#/Expiration date:	Place label here. Second Dose (if applicable)
Today's Date:	Second dose administered by: