

The following questions will help determine if there is any reason we should not give you (or your child) the flu vaccine. Answering "yes" to any question does not necessarily mean you (or your child) should not be vaccinated. It simply means additional questions must be asked. If a question is unclear, please ask your healthcare provider to help explain.

Patient information

<hr/>		
First name	Last name	
<hr/>		
Suffix (optional)	Date of birth (MM/DD/YYYY)	Age
<hr/>		
Parent/guardian first name		

Contact information

<hr/>		
Mailing address	City	Zip code
<hr/>		
Mobile number	Email address	

Gender

- Female Male Non-binary Prefer not to say

Hispanic, Latino, or Spanish origin

- | | | | | | |
|--|--|--------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Argentinian | <input type="checkbox"/> Colombian | <input type="checkbox"/> Costa Rican | <input type="checkbox"/> Cuban | <input type="checkbox"/> Honduran | <input type="checkbox"/> Guatemalan |
| <input type="checkbox"/> Hispanic, Latino/
Spanish Origin | <input type="checkbox"/> Mexican, Mexican
American, Chicano | <input type="checkbox"/> Nicaraguan | <input type="checkbox"/> Panamanian | <input type="checkbox"/> Peruvian | <input type="checkbox"/> Puerto Rican |
| <input type="checkbox"/> Salvadorian | <input type="checkbox"/> Other South
American | <input type="checkbox"/> Other | <input type="checkbox"/> Not of Hispanic,
Latino or
Spanish origin | <input type="checkbox"/> Prefer not
to say | |

Race/nationality (check all that apply)

- | | | | | | |
|--|---------------------------------------|--------------------------------------|---|------------------------------------|--------------------------------------|
| <input type="checkbox"/> American Indian
or Alaska native | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Bangladeshi | <input type="checkbox"/> Black or African
American | <input type="checkbox"/> Cambodian | <input type="checkbox"/> Chamorro |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Fijian | <input type="checkbox"/> Filipino | <input type="checkbox"/> Guamanian | <input type="checkbox"/> Hawaiian | <input type="checkbox"/> Hmong |
| <input type="checkbox"/> Indonesian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Laotian | <input type="checkbox"/> Malaysian | <input type="checkbox"/> Marshallese |
| <input type="checkbox"/> Middle Eastern or
North African | <input type="checkbox"/> Pakistani | <input type="checkbox"/> White | <input type="checkbox"/> Other | | |

Health insurance

Do you have health insurance? Yes No

If yes,

Insurance provider	Primary carrier's full name
Relationship with primary carrier	Policy number

Medical screening questions

Is the patient feeling sick today? Yes No

Does the patient have an allergy to an ingredient of the influenza vaccine? Yes No

Has the patient ever had a serious reaction to influenza vaccine in the past? Yes No

Has the patient ever had Guillain-Barre Syndrome (GBS)? Yes No

Information on the risks and benefits of the flu vaccine

CDC recommends everyone 6 months and older get vaccinated every flu season. Children 6 months through 8 years of age may need 2 doses during a single flu season. Everyone else needs only 1 dose each flu season. To learn more about the risks, benefits, and side effects of flu, read the [CDC Vaccine Information Statement](#).

Minor consent

I declare that I am (must check one):

- The parent of the named minor child.
- The legal guardian of the named minor child.
- An emancipated minor at least 16 years of age.
- A person with authority to make healthcare decisions on behalf of the named minor child.
Describe legal relationship here: _____

I attest to the following

All boxes must be checked in order for the minor to be vaccinated:

- I have read and understand the Vaccine Information Statement for the requested vaccine and understand the risks and benefits.
- I GIVE CONSENT for the minor patient to receive the vaccine.

I attest to the following (Continued)

- I understand that by providing my voluntary consent, the minor patient can receive the vaccine with or without a parent or guardian being physically present at the vaccination appointment.
- I consent to and authorize all medically necessary treatment in the rare event that the minor patient has a reaction to the vaccine.

Parent/guardian information

Please write your full name

Email address

Mobile number

Address (Street number & name, City, State, Zip code)

By signing my name and today's date below, I am providing consent for the named minor child to receive the flu vaccine and certify that (1) I am authorized to provide this consent and (2) all of the information I have provided on this form is true and correct to the best of my knowledge:

Parent/guardian signature

Date signed (MM/DD/YYYY)

For staff use only

Name

Signature

Date

Time

Clinic

Product

Dose no.

Dose (ML)

Asset name

Injection site: RD LD RL LL

Route: IM SQ