CHILD 6 months-18 years
2022-2023 FLU VACCINES
SCREENING, CONSENT & ADMINISTRATION FORM

Rev 8/9/2022

MYRTUE Medical Center

Last name ________________________First name ________________________Middle initial____

Address: _____________________________City:______________________State_______ Zip_________

Date of Birth: _________________Age: _________(months or years)   (circle) Male or Female

Name of parent/guardian:____________________ Daytime phone #______________________________

CIRCLE the line below that describes this child:

- Is enrolled in Medicaid #___________________ (*fill in number or show Medicaid card to clerk*)
- Does not have any health insurance
- Has health insurance that DOES NOT pay for flu vaccines
- Is American Indian or Alaskan Native

} VFC stock- no charge for vaccine.

- Has Blue Cross/Blue Shield or Aetna that will pay for the flu vaccine. *Attach a copy of your card.*
- We have other insurance that will pay for this. I agree to pay by cash or check.

} PRIVATE Stock

(Circle→) Private or VFC (circle→) (6 months-19 years) injectable vaccine or   Flu Mist (2-19 years)

Paid $________ (circle→) Cash or Check# ________ Receipt given by _____ *(initials)*

I agree to the following:

1. To have my insurance billed, or if the insurance does not pay the whole amount, I agree to pay the difference.
2. I have been offered or have read a copy of the Vaccine Information Sheet provided or have had the information explained to me.
3. I accept responsibility for seeking medical attention for any problems with this vaccine.
4. This child has not had an allergic reaction after a previous dose of influenza vaccine or has any severe, life-threatening allergies, and does not have a fever or other symptoms of moderate to severe illness.
5. If my child is age 6 months to 8 years old, they may need a second dose of flu vaccine in 4 weeks. I agree to bring this child back in 4 weeks or more if he/she needs the second dose of flu vaccine to be protected.

If requesting Flu Mist intra-nasal spray: Your child is not eligible for live vaccine if you answer yes to any questions below:

- Received any vaccine in the last 4 weeks? No or yes/explain:____
- Taken an anti-viral medicine such as Tamiflu or Relenza in the past 48 hours? No or yes/explain______________________
- Is a child taking long-term aspirin therapy? No or yes/explain____
- Have a weak immune system such as with HIV, chemotherapy, or daily steroids? No or yes/explain____________________
- Is pregnant or possibly pregnant? No or yes____
- Has close contact with a person that has a weakened immune system? No or explain_____________________________
- Is a child 2-4 years of age with history of asthma or wheezing in past 12 months or is 5 years or older and has asthma. Yes or No
- Has underlying medical conditions such as heart, lung, kidney, liver, neurologic, metabolic, or neuromuscular disorders?   Yes or No

Sign to consent for child to receive vaccine: ____________________________ Date: __________________

FOR OFFICE USE BELOW

Immunization Date	Manufacturer/Brand//Lot (ok to use sticker)	IM Route: Circle route, dose, & site	Flu Mist nasal spray:	Vaccinator Signature	Date entered into IRIS Initials
		0.25 ml IM 0.5 ml IM **L or R** **Arm or thigh**	0.2 ml (1/2 dose into each nostril)		