CHILD 6 months-18 years
2020-2021 FLU VACCINES
SCREENING, CONSENT & ADMINISTRATION FORM

Rev 8/1/2020

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/Wellmark 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→) (3 and up) shot $50/ (6 months to 19 years) Flu Mist $69

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 dated 8/15/19 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 does not have a severe allergy to eggs, does not have a fever, & has never had a serious reaction to a previous flu vaccine.
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.
6. 6. The child does not have moderate to severe illness or symptoms of COVID-19.

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 2 weeks? 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

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
		0.25 ml IM 0.5 ml IM **L or R** **Arm or thigh**	0.2 ml (1/2 dose into each nostril)	

Entered into IRIS by _____ date_____ Dose #2 Entered into IRIS by _____ date_____