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# **CHILD 6 months-18 years**

# **2025-2026 FLU VACCINES**

# **SCREENING, CONSENT & ADMINISTRATION FORM**

Rev 8/14/2025

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

* 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.

 ***(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)*

Child’s mother’s maiden name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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.
6. 6. The child does not have moderate to severe illness or symptoms of COVID-19.

***FOR OFFICE USE BELOW\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\* Please review or give current VIS sheet to patient.***

PRIVATE Stock

Sign to consent for child to receive the vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VFC stock-no charge for vaccine.

***\*\*\*\*\*\*\*\*\*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** |
|  |  | **0.5 ml IM****L or R****Arm or Thigh** |   0.2 ml (1/2 dose into each nostril) |  |