Date:_____ Chart #: _____

Office Use Only: ☐ VFC ☐ PRIVATE

Marquette County Health Department Seasonal Influenza Vaccine Program

Child Form (*6 months through 18 years of age)*

Child's Legal Name: _____ **Date of Birth:** _____ **Age:**_____

Address: _____ **City**: _____

Phone: _____ **Sex:** ☐ Male ☐ Female

FLU MIST IS NOT AVAILABLE THIS FLU SEASON

Race: ☐White ☐Asian ☐Black/African American ☐Native Alaskan/American Indian ☐Native Hawaiian/Pacific Islander

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Are you enrolled in any of the following?: (Please present your insurance card to registration)

☐ Medicaid ☐ Medicare Part B ☐ No Medical Insurance ☐ Cash/Check/Credit

☐ Insurance **WITH** Immunization Coverage ☐ Insurance **WITHOUT** Immunization Coverage

***Attach copy of insurance card or provide the following information**:

Insurance Carrier Name: _____ **Policy #:** _____

Card Holder's Name: _____ **Card Holder's Date of Birth**: ____/____/____

Card Holder's Phone #: _____ **Relationship to Child**: _____

Medical Screening Questionnaire & Consent for Vaccination

YES	NO	
		1. Have you ever had a serious reaction to a vaccine?
		2. Are you allergic to eggs or any antibiotics?
		3. Have you ever had Guillain-Barre syndrome (GBS)?
		4. Are you currently ill or running a fever?

"I have read or have had explained to me the information in the vaccine information statement (VIS). I have also had a chance to ask any questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine." *(Initial here)* _____

Marquette County Health Department has made their Privacy Act practices available to me.
(Initial here) _____

"I authorize the release of any medical or other information with respect to this vaccine to Medicare, Medicaid or other third party payer as needed to request payment of authorized benefits to be made on my behalf to Marquette County Health Department. I acknowledge that if my insurance does not cover the cost of administering the vaccine then I will be responsible for any balance on my account for which I will receive a statement. "

_____ _____

SIGNATURE of Responsible Party **DATE**

Printed Name of Responsible Party: _____ **Phone:** _____

THIS SIDE OF FORM TO BE COMPLETED BY MARQUETTE COUNTY HEALTH DEPT STAFF ONLY

Nurse Staff:_____ **Date Vaccine Administered:** _____

Vaccine	Manuf.	Lot #	Route	Site	Nurse Signature
Flu Q (IIV4) 0.5mL (Fluzone)	Sanofi		IM	RD LD RT LT	
Flu Q (IIV4) 0.25mL (6 mo. To 2 years)	Sanofi		IM	RD LD RT LT	

Nurse Notes:

_____

_____

_____

_____

_____

_____

_____

_____