Consent to Administer Influenza Vaccination

Demographics:

Patient Name: _____

DOB: _____/_____/_____ **Age**: _____

Street Address: _____ **Town/City**: _____

County:_____ **State**: _____ **Zip**: _____

Gender (please check one): ☐ Female ☐ Male ☐ Other ☐ Decline to Specify

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Unknown ☐ Decline to Specify

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ Decline to Specify

Does the person being vaccinated currently have Medicaid, Well Sense, NH Healthy Families or AmeriHealth Caritas? ☐ Yes ☐ No

SCREENING QUESTIONS	Yes	No	Don't Know
Have you received an influenza vaccine in the past?			
Are you feeling sick today?			
Have you ever had a severe reaction to the influenza vaccination? *Allergic reactions can include symptoms like rash, hives, swelling of face or mouth, wheezing and difficulty breathing, etc. – Please specify:*			
Do you have a known allergy to an ingredient in the influenza vaccine *See the provided age-appropriate FDA Fact Sheet for a list of vaccine ingredients.*			
Do you have an allergy to eggs or egg products?			
Have you ever had any allergic reaction within 4 hours of receiving a non-influenza vaccine or other injectable medication (including medications injected into a muscle, vein, or under the			
Have you ever had a severe allergic reaction (like anaphylaxis due to any other cause, including medications taken by mouth, food, or other substances?			

Did you develop Guillain-Barré syndrome (GBS)?			
Are you pregnant?			
Do you have a bleeding disorder or are you taking blood thinners?			

Consent**:**

I hereby acknowledge the following: (please initial)

_____ I have completed the appropriate health screening questionnaire prior to vaccination and have no known contraindications to this vaccination.

_____ I have been provided with a copy of, and reviewed the contents of, the age-appropriate FDA Fact Sheet for people receiving the Influenza vaccine.

_____ I acknowledge that I have received and reviewed the information provided and I confirm that the information entered on this form is accurate to the best of my knowledge.

_____ I acknowledge that I am required to wait a minimum of 15 minutes after administration of the vaccination before leaving the vaccination site.

I understand, as a condition of receiving the Influenza vaccine today, my personal health information, or that of my child/ward, may be shared as allowable under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (see DHHS Notice of Privacy Practices).

I understand unless I have **SIGNED THE SEPARATE** *Choose not to Participate in the NH Immunization/Vaccination Registry* form exercising my right to opt out under NH RSA 141-C:20-f, and NH Administrative Rule He-P 307.06, and have checked the box below, my immunization information will also be entered into the NH Immunization/Vaccination Registry.

- I choose **NOT** to participate in the NH Immunization/Vaccine Registry (MUST COMPLETE SEPARATE FORM)

I consent to the administration of the Vaccine by the Regional Public Health Department. I fully release and discharge Regional Public Health Department, its affiliates and their officers, directors, employees and persons acting on their behalf or at their direction from any liability or claim related to the administration of, or receipt of, the Vaccine.

Signature of Vaccine Recipient: _____ Date: _____

Printed Name of Vaccine Recipient: _____

Phone Number: _____
Email Address: _____

Vaccine:_____ VIS/EUA Date: _____ Lot #: _____
Exp Date:_____ Dose amount: _____ Site: _____ Date Admin: _____
Time Given: _____ Admin by: _____
Clinic Name: _____