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LINN COUNTY HEALTH DEPARTMENT CHILD INFLUENZA CONSENT

ALL INFORMATION MUST BE COMPLETE FOR YOUR CHILD TO BE ELIGIBLE TO RECEIVE VACCINE. PLEASE PRINT CLEARLY

LAST NAME	**FIRST** NAME	**M.I.**	DATE OF BIRTH	AGE / GRADE

STREET ADDRESS	CITY	ZIP CODE	MALE / FEMALE

Check insurance status for your child

____is on Medicaid/MO Healthnet (please provide number) _____

____has no health insurance

____underinsured

____American Indian/Alaskan Native

X Inactivated (Flu Shot) VIS 08-15-19

Do any of the following apply to your child? Please circle correct answer.

Currently sick? **YES NO**

Serious allergic reaction to eggs or component of any flu vaccine? **YES NO**

Serious reaction to a previous dose of flu vaccine? **YES NO**

Experienced Guillain-Barre' Syndrome? **YES NO**

Health conditions such as: Asthma, Reactive Wheezing, Diabetes, Heart, Lung, Kidney, or Blood Illnesses? **YES NO**

Currently receiving aspirin or aspirin-containing therapy? **YES NO**

Weak immune system or taking medicine that lowers the body's resistance to infection? **YES NO**

Pregnant or breastfeeding? **YES NO**

Has close contact with a person whose immune system is severely compromised & kept in isolation? **YES NO**

I have been given & have read or had explained to me the inactivated influenza, VIS (08-15-19) & had questions answered to my satisfaction. I understand the benefits & risks of the vaccine. I authorize vaccine administration to the child named above for whom I am authorized to make this request.

X_____

SIGNATURE OF PARENT OR LEGAL GUARDIAN 18 YEARS OR OLDER DATE

****************************HEALTH DEPARTMENT USE ONLY********************************

Manufacturer & Lot	SITE	
Sanofi Inactivated Flu Vaccine **FLUZONE**	0.5cc IM (L) Delt (R) Delt (L) Vast Lat (R) Vast Lat	**Linn Co. Health Dept.** **635 S. Main St.** **Brookfield, MO 64628** **660-258-7251**
*Vaccinator initials/Date Given		

*Signature/credential initials of vaccinator retained by Linn Co. Health Dept.