Influenza Vaccination
Assessment, Release & Consent Form
(PLEASE PRINT)

Name_____
Last First Middle Initial

Address: (Street) _____

City_____ County_____ State_____ Zip_____

Phone Number_____ Birth date_____/_____/_____ Age_____ Sex
M____ F____

Please check one of the following about the child.

- ☐ Has Medicaid
- ☐ Has health insurance that does not pay for vaccines
- ☐ Does not have health insurance
- ☐ Is American Indian or Alaskan Native

Please check answer

1. Are you allergic to chicken, eggs, or chicken feathers? _____ Yes _____ No
2. Are you allergic to thimerosal-containing products (eye contact lens solution) or mercury containing products (Merthiolate)? _____ Yes _____ No
3. Have you ever had a reaction or any other problems after receiving a flu shot? _____ Yes _____ No

For any "yes" answers, consult physician before the administration of vaccine.

I have read the information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. I authorize billing of this vaccination to Medicare and accept responsibility for any charges denied by Medicare.

Acknowledgment of Receipt of the Notice of Privacy Practice

I understand, that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). The Notice of Privacy Practice, which explains those rights, has been made available to me.

Signature _____ Date_____

FOR NURSES USE ONLY

Site: RD / LD Lot#_____ Date Vaccine Administered_____

Manufacturer Glaxo Smith Kline Administered

By_____

WAPELLO COUNTY PUBLIC HEALTH
108 E. MAIN STREET
OTTUMWA, IA 52501

(641)682-5434

Wednesday, October 27th 2021

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. Does the child have a parent, brother, or sister with an immune system problem?	☐	☐	☐
10. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
13. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

immunization action coalition
IAC
immunize.org

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (6/20)