Influenza/Pneumococcal Immunization Consent Form

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Immunization

Name (Please Print)	Date of Birth	Sex	County of Residence
Address	City	State	ZIP
Phone	For Persons Under 19 Years Old, Mother's Maiden Name		
Medicare Claim Number	Doctor's Name		
Health Insurance Provider	Doctor's Address		
Policy Number	Clinic/Office Site Where Vaccine Administered	NYSIIS Permission ≥ 19 Years Old ☐ No ☐ Yes	

Please complete the questions below for yourself or the person receiving the vaccine.

☐ No ☐ Yes Are you currently sick with a fever?

☐ No ☐ Yes Have you ever had a life threatening allergy to any component (or part) of the flu or pneumonia vaccine?
If yes, please describe: ____________________

☐ No ☐ Yes Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving flu vaccine?

☐ No ☐ Yes Have you ever had a pneumonia shot?

☐ No ☐ Yes Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease?
If yes, please describe: ____________________

☐ No ☐ Yes Have you ever had a severe life threatening allergy to eggs or egg products?

☐ No ☐ Yes Are you currently pregnant?

☐ No ☐ Yes Do you have a history of asthma or wheezing?

☐ No ☐ Yes Are you a child or adolescent receiving long-term aspirin therapy?

☐ No ☐ Yes Do you have a weakened immune system or have close contact with a person with an extremely weakened immune system who needs special care?

☐ No ☐ Yes Have you received any other vaccinations within the last 4 weeks?

☐ No ☐ Yes Have you taken an antiviral medication for the flu within the last 48 hours?

Influenza Consent
I have read, or had explained to me, the Vaccine Information Statement about **influenza** vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the **influenza** vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

Signature of Recipient (Parent or Guardian) Date

Pneumococcal Consent
I have read, or had explained to me, the Vaccine Information Statement about **pneumococcal** vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the **pneumococcal** vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

Signature of Recipient (Parent or Guardian) Date

Area Below to Be Completed by Nurse

Influenza Vaccine

Administration Date ____________________

Administration Site ☐ Left Arm ☐ Right Arm ☐ Nasal
☐ Left Thigh ☐ Right Thigh

Dosage ☐ 0.5 ml ☐ 0.25 ml ☐ LAIV

Manufacturer & Lot Number ____________________

VIS Date ____________________

Nurse Signature ____________________

Next Immunization Due: ☐ Next Year ☐ In 4 Weeks ☐ Other ________

Pneumococcal Disease Vaccine

Administration Date ____________________

Administration Site ☐ Left Arm ☐ Right Arm
☐ Left Thigh ☐ Right Thigh

Manufacturer & Lot Number ____________________

VIS Date ____________________

Nurse Signature ____________________

Next Immunization Due: ☐ None Needed ☐ Other ________

DOH-4156 (6/14) Immunizer – White Provider – Yellow Patient – Pink

SAMPLE

REFERENCE: New York State Department of Health. Influenza/pneumococcal immunization consent form. https://www.health.ny.gov/forms/doh-4156.pdf. Updated 2014. Accessed May 15, 2015.

Annual Influenza Vaccine Consent Form
FLU SHOT and NASAL SPRAY

IM and Intranasal Form

Section 1: Information about Child to Receive Vaccine (please print)

STUDENT'S NAME (Last)		(First)	(M.I.)	STUDENT'S DATE OF BIRTH month_______ day_______ year _________	
PARENT/LEGAL GUARDIAN'S NAME (Last)		(First)	(M.I.)	STUDENT'S AGE	STUDENT'S GENDER M / F
ADDRESS				PARENT/GUARDIAN DAYTIME PHONE NUMBER:	
CITY	STATE	ZIP			
STUDENT'S DOCTOR'S NAME (Last, First)		Address		City	Zip
SCHOOL NAME		HOMEROOM TEACHER'S NAME		GRADE	

Section 2: Screening for Vaccine Eligibility

Please mark YES or NO for each question.

Has your child been vaccinated with the seasonal influenza vaccine after July 1, 2010? YES ☐ NO ☐

The following four questions will help us to know if your child can get the intranasal influenza vaccine. If you answer "NO" to all of them, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following questions, your child may be able to get the seasonal influenza vaccine, but we will contact you to discuss your options.	**YES**	**NO**
1. Does your child have a serious allergy to eggs?	☐	☐
2. Does your child have any other serious allergies? Please list: ____	☐	☐
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐
There are two kinds of seasonal influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine your child can get.		
1. Has your child gotten vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: __________________________________ Date given: month______day_______year___________	☐	☐
2. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	☐	☐
3. Is your child on long-term aspirin or aspirin-containing therapy (for example, does your child take aspirin every day)?	☐	☐
4. Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	☐	☐
5. Is your child pregnant?	☐	☐
6. Does your child have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	☐	☐

Section 3: Consent

CONSENT FOR CHILD'S VACCINATION:
I have read or had explained to me the 2010-2011 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

☐ **I GIVE CONSENT** to the NAME OF ORGANIZATION CONDUCTING CLINIC and its staff for my child named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then you child will not be vaccinated)

☐ **I DO NOT GIVE CONSENT** to the NAME OF ORGANIZATION CONDUCTING CLINIC and its staff for my child named at the top of this form to be vaccinated with this vaccine.

Signature of Parent/Legal Guardian ____ Date: month_____day_____year__________

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
Influenza	☐ IM ☐ Intranasal	/ /			

SAMPLE

REFERENCE: Annual influenza vaccine consent form-flu shot and nasal spray. Centers for Disease Control and Prevention website. http://www.cdc.gov/flu/school/slv/support.htm. Updated 2015. Accessed May 15, 2015.