REDFIELD CLINIC

2021-22 CHILD/ADOLESCENT INFLUENZA VACCINE PARENT/GUARDIAN CONSENT FORM

Form must be complete for child to receive vaccine. Please Print.

Last name:_____ First Name:_____MI:_____

Gender: M_____ F_____ Age:_____ Date of birth:_____ Daytime Phone:_____

Mailing Address:_____Zip Code:_____

_____**Please check** if you are a CMH/Redfield Clinic Healthcare Worker/Family Member, Redfield City Employee/Family Member, or Spink County First Responder. Service will be billed to insurance; remaining balance is waived.

Please circle one: Self Pay Medicaid Insurance

Medicaid Number, if applicable_____Primary Medicaid Provider_____

Insurance Company_____ Insurance Company Address_____

Policy Holder's Name_____Policy Number_____Group Number_____

I have been given, read, or have been explained to the information in the Vaccine Information Statements for Influenza Vaccine. I understand the benefits and risks of Influenza Vaccine and request that this vaccine be given to the person above for whom I am authorized to make this request. I allow immunization information to be entered into the SD Immunization System (SDIIS) and/or be released to other medical care providers to prevent unnecessary vaccination or to ascertain immunization status**.**

Please answer the following questions for the person to be vaccinated.

Is child sick today?	YES	NO	DON'T KNOW
Has child had a serious reaction to a vaccine in the past?	YES	NO	DON'T KNOW
Does child have allergies to mediations, food, a vaccine component or latex?	YES	NO	DON'T KNOW

_____

Printed Name of Parent/Legal Guardian

_____

Signature of Parent/Legal Guardian Date

For Clinic Use Only:

Child may receive Influenza Vaccine: Yes No

Date	Vaccine	Manuf.	Lot Number Expiration date	Dose	Route	VIS	Site	Source	Nurse administering vaccine
				0.5ml	IM	08/06/21	L R Deltoid Thigh	Private State	

SDIIS_____