| **BRANCH HILLSDALE ST. JOSEPH COMMUNITY HEALTH AGENCY: INFLUENZA CLINIC FORM**<br>**Please enter your child's information here.** | | |
|---|---|---|
| **Last Name:** | **First Name:** | **Middle:** |
| **Gender:** | **DOB:** | **Age:** |
| **Street Address:** | | **Phone:** |
| **City:** | **State:** | **Zip Code:** |

**Screening Checklist for Contradictions to Inactivated/Live Injectable/Intranasal Influenza Vaccination**

**1.** Is the person to be vaccinated sick today? **Yes ☐ No ☐ NA ☐**

**2.** Does the person to be vaccinated have an allergy to a component of the vaccine? **Yes ☐ No ☐ NA ☐**

**3**. Has the person to be vaccinated ever had a serious reaction to flu vaccine in the past? **Yes ☐ No ☐ NA ☐**

**4**. Has the person to be vaccinated ever had Guillain-Barré syndrome? **Yes ☐ No ☐ NA ☐**

**5**. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, or metabolic disease (e.g., diabetes)? **Yes ☐ No ☐ NA ☐**

**6.** Is the person to be vaccinated receiving or has recently received influenza antiviral medications? **Yes ☐ No ☐ NA ☐**

**7.** Is the person to be vaccinated a child or teen age 6 months through 17 years and receiving aspirin- or salicylate-containing medicine? **Yes ☐ No ☐ NA ☐**

**8.** Is the person to be vaccinated pregnant or could she become pregnant? **Yes ☐ No ☐ NA ☐**

**9.** Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)? **Yes ☐ No ☐ NA ☐**

**10.** Has the person to be vaccinated received any other vaccinations in the past 4 weeks? **Yes ☐ No ☐ NA ☐**

**11.** Do you have a preference between Flu injection or FluMist? **Injection ☐ Mist ☐ No preference ☐**

**You must fill out insurance information on the back of this form for injection flu.**

_____ _____ _____

**Parent Name (Print)** **Parent Signature** **Date**

By signing I certify that the answers to the above questions are true to the best of knowledge, I have reviewed and received the vaccine information statement and I give consent for my child to receive an influenza vaccine from BHSJ CHA.

**Please explain any "YES" answers from the above questions here:**

# Insurance Information

***You can skip the insurance portion if you have selected FluMist for your child. ***

## Primary Insurance: Subscriber's Information

| | | |
|---|---|---|
| **Name of Primary Insurance:** | | |
| **Subscriber Name:** | **Subscriber Address:** | |
| **Subscriber DOB:** | **Group Name:** | |
| **Subscriber ID:** | **Group Number:** | **Subscriber Gender:** |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the BHSJ CHA. I understand that I am financially responsible for any balance if my insurance does not cover for vaccine/s given or I do not qualify for any special programs. I hereby consent to the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to BHSJ CHA associated with the services contemplated herein.

My signature on this form indicates that I have requested that the vaccine indicated below be administered to my child by a BHSJ CHA representative. I relieve the BHSJ CHA and the administering nurse and personnel of any liability for any reactions that should occur. In the case of occupational exposure, BHSJ CHA has patient permission for blood testing for patient and employee safety alike. I have read or have had explained to me the information on this form.

_____ _____ _____

**Parent Name (Print)** **Parent Signature** **Date**

## FOR HEALTH DEPARTMENT USE ONLY

| | | | |
|---|---|---|---|
| **Influenza** | **MRF/LOT** | **VIS Literature 8/15/2019** | **SITE: LD☐ RD☐** |
| **Influenza** | **MRF/LOT** | **VIS Literature 8/15/2019** | **SITE: LD☐ RD☐** |
| **Flu Mist** | **MRF/LOT** | **VIS Literature 8/15/2019** | **SITE: NASAL ☐** |

**By signing, I certify that the patient in question has been given VIS literature and that any and all applicable questions and forms were answered and reviewed prior to vaccine administration.**

_____ _____

**Nurse Signature** **Date**