521 NORTH MAIN AVENUE, SIOUX FALLS, SD 57104
MEDICAL CLINIC 605-367-8793
DENTAL CLINIC 605-367-8022

Influenza Vaccine Consent Form

Patient Name: ______________________________ Gender: ☐ Male ☐ Female
Last First Middle Initial

Address: ______________________________
Street Apt. No. City State Zip

Phone Number: ____________ Emergency Contact Name: ____________ Emergency Number: ____________

Influenza Vaccine Consent & Medical Information

I understand the benefits and risks of the influenza vaccine and request that it be given to me or to the person named on this form for whom I am authorized to make this request. I have been provided a copy of the Influenza Vaccine Information Sheet (published August 6, 2021) and am aware of any possible side effects.

1. Do you have a history of allergy to eggs or egg products? ☐ Yes ☐ No
2. Do you feel sick today or are you running a fever? ☐ Yes ☐ No
3. Have you ever had a serious reaction to the flu vaccine? ☐ Yes ☐ No ☐ Never had a flu shot
4. Have you ever had Guillain-Barré Syndrome? ☐ Yes ☐ No

Notice of Privacy Practices

I have been notified that I can obtain a copy of this office's Notice of Privacy Practices by contacting the clinic at 605-367-8793 or from our website at www.siouxfalls.org/fch.

Sharing of Information from School District

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of students' personal information held by educational agencies or institutions.
I give the Bishop O'Gorman Catholic Schools permission to share personally identifiable student information with Falls Community Health. This information will only be used to coordinate care with FCH. The information shared will be limited to demographic and health history.

Authorization

______________________ ______________________ __________
Signature of Parent Print Name/Relationship Date

FOR OFFICE USE ONLY

Date of Administration: 10-20-2021 VIS Given: X

Site of Administration: ☐ R Deltoid ☐ L Deltoid ☐ R Thigh ☐ L Thigh

Manufacturer: ☐ Sanofi ☐ Novartis X Glaxo ☐ ____________

Dose: ☐ 0.5 ml ☐ 0.25 ml Lot # 3T4DH Exp. Date: 06/30/2022

Administered by: ______________________________