Clinic Location:
Clinic Date:

Santa Barbara County PUBLIC Health DEPARTMENT

INFLUENZA VACCINE SCREENING AND CONSENT FORM

Please Print

First Name: _____ **Last Name:** _____

Date of Birth (MM/DD/YYYY): ____/____/_____ **Age**: ☐

Gender: ☐ Male ☐ Female ☐ Other **Mother's First Name:** _____

Race: *(check one)*
☐ American Indian/Alaska Native ☐ Native Hawaiian or Pacific Islander
☐ Asian ☐ White
☐ Black/African American ☐ Other Race:

Ethnicity: *(check one)*
☐ Hispanic or Latino ☐ Not Hispanic or Latino

Email Address: _____ **Cell Phone Number:** _____

Address: _____ **City**: _____

Zip code: _____ **County**: Santa Barbara

Insurance: ☐ Private ☐ Medicaid/Medical Assistance ☐ Medicare ☐ No Insurance

	Yes	No
1. Is the person to be vaccinated sick or have a fever today?	☐	☐
2. Has the person to be vaccinated had a severe (life-threatening) allergic reaction to eggs, Gentamicin, or a previous dose of influenza vaccine?	☐	☐
3. Has the person to be vaccinated ever had Guillain-Barre Syndrome?	☐	☐
4. Is this the first time the person to be vaccinated has ever received any type of flu vaccine?	☐	☐

	Yes	No
Question below to be completed for children 2 - 8 years old only		
5. Is this the first dose of flu vaccine for a child 8 years or younger?	☐	☐

I have read or had explained to me the "Influenza Vaccine Information Statement". I have had the opportunity to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and request that it be given to me or to the person for whom I am authorized to make this request.

Signature: _____ **Date** _____

This Section to Be Completed by Staff

Screener Name: _____ Vaccinate? ☐ YES ☐ NO-Refer to Medical Assessment

Medical Assessment by *(if assessment required)*: _____ Vaccinate? ☐ YES ☐ NO
(Screener or Assessor must include: Initial of First Name, Full Last Name and professional suffix – MD, RN)

☐ This is a first-time flu shot. Advised to go to the 15-minute observation area.

Vaccinator: ***Check box to indicate the Manufacturer & fill in the Lot # and administration site***

☐ **Prefilled .5ml Fluarix Quadrivalent GSK** (licensed for 6months and up) **Lot #** _____

IM Administration Site *(circle)*: **L / R Deltoid** **L / R Vastus Lateralis**

Administered on: _____*(Date)*

Administered by: _____ *(circle)* **RN / SRN /SLVN**
LEGIBLY PRINT your full name