CONSENT FOR INFLUENZA VACCINE

Please fill out this form for yourself or your minor child or the person for whom you have legal guardianship. Mother's maiden name, address, and date of birth are needed to confirm that the correct person is identified in the medical record which tracks immunizations. Email will help us serve you better.

Client Name: ________________________________ Phone: ______________________
Date of Birth: _____________________ Mother's Maiden Name: ___________________
Client's Address:____
E-Mail ____

Has the client **EVER** had an influenza (FLU) vaccine? Yes □ No □
Does the client have allergies to eggs, other vaccine components, or latex? Yes □ No □
Has the client had a serious reaction to the influenza FLU vaccine in the past? Yes □ No □

PLEASE CHECK ALL THAT APPLY:

□ SRPMIC - Enrolled Member

□ SRPMIC - Community Resident

□ SRPMIC - Family of Enrolled Member

□ SRPMIC - Family of Community Resident

□ SRPMIC or Enterprise Employee: Please provide department or enterprise in which you **or your family member** works:

Department ____

CONSENT FOR VACCINATION

I am the client or parent/guardian of the client identified above AND I give permission for this client to receive Influenza Vaccine.
I have received and read the vaccination information sheet (Current CDC VIS Statement) regarding the influenza vaccine. I understand the risks and benefits, and give consent to the Salt River Pima-Maricopa Indian Community (SRPMIC) and its authorized staff to administer the vaccine to me. I hereby release and forever discharge myself, my heirs, executors, administrators and assignees, SRPMIC and their representatives employees and governing bodies from any and all claims, demands, actions and causes of action, which may result from participation in this program. In addition. I consent to have information regarding my vaccination to be shared with my primary care provider if the provider practices within an Indian Health Service Clinic, otherwise I will communicate the information provided to me about my vaccination to my primary care provider.

____ ________________________
Print Name of Client (if over age 18) or Parent/Guardian Relationship

____ ________________________
Signature of Client (if over age 18) or Parent/Guardian Date

FOR ADMINISTRATIVE USE ONLY	
INFLUENZA QV SEASONAL VACCINE	Ill with a fever today: Yes ☐ No ☐ Temp:______________________ Manufacturer: ____________________ Expiration Date: Lot #: __________________ ☐ R Deltoid ☐ L Deltoid ☐ R Thigh ☐ L Thigh ☐ 0.5 ml IM ☐ 0.25 ml IM Administered by: ________________________Date:______________________________