SCHOHARIE COUNTY DEPARTMENT OF HEALTH
CHILD HEALTH IMMUNIZATION CONSENT FORM

PLEASE PRINT:

Child's Last Name:	First Name:	Age:	Birth Date:	Sex:: M/F
____________	____________	____	________	

Child's Mailing Address: ____

____
(#, Street, Town)

Telephone #: ______________________

Parent/Guardian's Name: ______________________________________

INFLUENZA VACCINE

PLEASE ANSWER THE FOLLOWING: **YES/NO**

1. Does your child have an egg allergy? ____________
   Type of reaction ______________________
2. Has your child ever had seizures with or without a fever? ____________
3. Has your child ever had Guillain Barre syndrome? ____________
4. Is this your child's first time getting flu vaccine? ____________

I have been offered the influenza vaccine information form, a copy of the Schoharie County Department of Health Privacy Practice Notice (HIPPA) and Patient Bill of Rights .

______________________________ ____________________
(Signature/Parent or Guardian) (Date)

Administration Date ____________________

Administration Site ☐ Left Arm ☐ Right Arm
☐ Left Thigh ☐ Right Thigh

Dosage 0.5 ml

Manufacturer & Lot Number: UI826AD exp. 6/30/2018

VIS Date: 8/7/2015

Nurse Signature ____

Next Immunization Due: x Next Year ☐ in 4 Weeks ☐ Other