PARK COUNTY HEALTH DEPARTMENT

INFLUENZA VACCINATION CONSENT FORM—MINORS

Child's Name (Last, First):_______________________________________ **DOB**: ____/____/________

Address: __________________________________City/State: ___________________________Zip Code: _________________

Phone Number: (______)________-____________ Gender (Circle one): **M F** Mother's First Name: ______________________

Primary Care Provider/Facility: ____

Race and Ethnicity Information (Optional, please check all that apply):

- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Hawaiian or Pacific Islander
- ☐ American Indian or Alaskan Native
- ☐ White
- ☐ Other:__________________

Insurance that your child has -(MUST CHOOSE ONE):

- ☐ No Health Insurance
- ☐ Healthy Montana Kids (BCBS)
- ☐ Healthy Montana Kids PLUS (Medicaid/VFC)
- ☐ Private Insurance, Vaccines Covered
- ☐ Private Insurance, Vaccines NOT Covered

Copy of Insurance Card is Preferred: (front and back)

If you have no insurance or vaccines are not covered, please pay $20 for each vaccine given.

If Card Copy is not provided, this portion MUST be filled out:

Card Holder Name:___________________________________

Card Holder DOB:____________________________________

Name of Insurance:___________________________________

Policy/Group #:______________________________________

Member ID:____

Please Circle Yes or No:

Does your child currently have a fever or illness?	YES	NO
Does your child have allergies to medications, eggs or any vaccines? List:_______________________	YES	NO
Has your child ever had Guillian Barre Syndrome?	YES	NO
Has you child ever had a reaction to past flu vaccines? (If yes, please explain on back of paper)	YES	NO
Has your child ever had a history of wheezing or asthma?	YES	NO
Does you child have a weakened immune system (HIV, cancer or medications such as steroids)?	YES	NO
Is the person receiving the vaccine currently pregnant?	YES	NO
Has your child received any vaccinations in the past 4 weeks? List:_______________________________	YES	NO

*****Feel free to explain any "YES" answers on the back of this paper.*

CONSENT FOR VACCINATION: I have read, or have had explained to me, the Vaccine Information Statement for the vaccine(s) that I have check marked. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine be given to the person named above for whom I am authorized to make this request. Park County Health Department will bill Medicaid/HMK (Plus) if the child is covered by those programs. I understand that a record of this immunization may be shared through ImMTrax (Montana's Immunization Information System).

SIGNATURE (Parent/Guardian):_______________________________________ Date: _______________________

Last updated 8/2018—CM

FOR STAFF USE ONLY: Fill out/place Label Sticker

Circle One: VFC Stock Private Stock

Vaccine Type: ____

Lot#:______________________ **Exp. Date:**________________

Manufacturer: ____

Staff Member's Signature: ________________ ___________________________

Date/Time given:________________________ **Inj. Site:** ______________

VIS Publication Date: ________________ VIS Given Date:___________________

Consent Filled out by Parents:	Date: Initials:	Notes:
Consent Given to Staff:	Date: Initials:	Notes:
Vaccination Given and Charted	Date: Initials:	Notes:
Billed Insurance	Date: Initials:	Notes:
Entered into ImMTrax	Date: Initials:	Circle One: VFC or Private