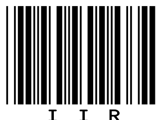
Lurie Children's Primary Care
Town & Country Pediatrics
Influenza Vaccination Consent



Medical Record No.
Patient Name
Birthdate
Physician
Please align patient label to the right

Lurie Children's Primary Care-Town & Country Pediatrics

Halsted

2016 – 2017 Flu Season

IF YOU ANSWERED YES TO ANY OF THE FOLLOWING SPEAK WITH THE NURSE!

1.	**DO YOU HAVE SEVERE ALLERGY TO EGGS?**	**YES or NO**
2.	**Have you had a flu vaccine in the last six months?**	**YES or NO**
3.	**Have you ever had Guillain-Barre Syndrome within 6 months of receiving a Flu Vaccine?**	**YES or NO**

Mild Reactions to Flu Shots	***Soreness at injection site *Mild fever *Muscle aches and fatigue within 6-12 hours post injection**
Severe Reactions (rare)	***Hives * Respiratory distress * Anaphylaxis**

If all answers to questions above are NO, please read this statement and sign below

INFLUENZA VACCINATION CONSENT

- I have read or have had explained to me the information about influenza and the influenza vaccine ***via the Vaccine Information Statement (VIS)***.
- I have had the chance to ask questions which were answered to my satisfaction.
- I believe I understood the benefits and risks of the influenza vaccine and request the vaccine be given to me.
- I hold harmless the Institution, its officers, employees and affiliated agencies from any and all claims which may result from injury or loss in any way associated with participation in this program.

For Children under the age of 18 years old (<18 yrs)

AUTHORIZATION TO RELEASE CHILD'S INFORMATION THROUGH THE ILLINOIS IMMUNIZATION REGISTRY

I hereby authorize Lurie Children's and its affiliates to release information concerning immunization records, including but not limited to, name, address, date of birth, types and dates of immunization to the Illinois Department of Public Health ("Department") for the inclusion in a centralized database of children's immunization records.

I understand that by authorizing the release of my child's Immunization Records to the Immunization Registry, I am authorizing their release to government health departments, public vaccine providers, community health centers, the Centers for Disease Control and Prevention, and any other person or entity providing immunization services or approved by the Department as needing to know the health or immunization status of my child ("Recipients").

I authorize the Recipients and the Department to use the Immunization Records that will be maintained in the Immunization Registry to provide immunization services to my child, to monitor my child's immunization status, to promote adherence to recommended immunization schedules, to assist in the preparation of vaccination documentation required by my child's school, to prepare statistical reports on immunization status of groups of patients in which neither my child nor any other patient may be individually identified and to otherwise monitor and promote the health of my child and children in Illinois generally.

I Authorize Lurie Children's and its affiliates to release information concerning immunization records as stated above: ☐YES ☐NO

Print Name: ______________________ **Date of Birth:** ____________**Phone**______________

Address: ______________________________**City**______________**State**______ **Zip**__________

Patient or Parent/Guardian (if <18 yrs) Signature: ______________________________**Date:** ____________

Lot # (Please check one):

Fluzone® Quadrivalent **0.25 mL** — **FOR PATIENTS > 6 months – 35 months old**

Sanofi Pasteur — Exp 6/30/17 — NDC: 49281-516-00

☐ Lot #UT5598LA ☐ Lot #UT5663KA ☐ Lot #UT5663UA

Fluzone® Quadrivalent **0.5 mL** — **FOR PATIENTS > 3 years old**

Sanofi Pasteur — Exp 6/30/17

☐ Lot #UT5673KA NDC: 49281-416-50 ☐ Lot #U5587BA NDC: 49281-416-58

RN/LPN/MA Signature: ______________________________ **Site:** ______________ **Date:** ______________