

Ascension Borgess Hospital

Pediatric Flu Immunization Consent

Age 6 months through 8 years

Please Print

Last Name	First Name	Middle	Phone Number
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Street Address	City	State	Zip Code
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Birthdate ____-__-____ Month Day Year	Age	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Name of Insurance (ex: Medicare, BCBS, United Healthcare, Priority Health, etc.)	
Member ID Number	Group Number (if available)
Provider Network (if available)	Policy/Contract Number

If insurance is not in patient's name, complete the following information		
Insured's Name	Insured's Birthdate ____-__-____ Month Day Year	Relationship to Insured <input type="checkbox"/> Spouse <input type="checkbox"/> Child

Please turn page over

Staff Use Only Administered by _____ Nurse Signature / Title	_____	_____
	Date	Time

For 3 years and up: <input type="checkbox"/> Left <input type="checkbox"/> Right Deltoid OR <input type="checkbox"/> Left <input type="checkbox"/> Right anterolateral aspect - thigh <input type="checkbox"/> 0.5 ml IM Seqirus Afluria (ages 3 years and up) <input type="checkbox"/> 0.5 ml IM GSK Fluarix (ages 6 months and up) <input type="checkbox"/> 0.5 ml IM GSK Flulaval (ages 6 months and up)	For 6-35 months: <input type="checkbox"/> Left <input type="checkbox"/> Right anterolateral aspect - thigh <input type="checkbox"/> 0.25 ml IM Seqirus Afluria <input type="checkbox"/> 0.5 ml IM GSK Fluarix <input type="checkbox"/> 0.5 ml IM GSK Flulaval
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Lot Code: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> H <input type="checkbox"/> I <input type="checkbox"/> J

Non-insurance payment	Amount paid: _____	<input type="checkbox"/> Cash	<input type="checkbox"/> Check # _____	<input type="checkbox"/> Bill Patient
Billing/payment/screening information verified by _____		Clinic No.. _____		
<input type="checkbox"/> COVID-19 health screen questions answered		<input type="checkbox"/> Temperature checked		



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Patient Name _____

Please circle the correct answer on the right

1. Has the child ever received the flu vaccine?	No	Yes
2. Has the child ever had a life-threatening reaction to a flu vaccine?	No	Yes
3. Is the child running a temperature of 101° F or over?	No	Yes
4. Is the child severely allergic to eggs, egg products, chicken, or chicken dander?	No	Yes
5. Does the child have a known allergy to contact lens solution or thimerosal (a mercury derivative)?	No	Yes
6. Has the child ever been paralyzed with Guillain Barre Syndrome?	No	Yes

- I have read and received a copy of the Inactivated Influenza Vaccine Information Statement prior to the child's vaccination.
- I understand the risks and benefits involved. I have had a chance to ask questions which were answered to my satisfaction. I want you to give the vaccine to the child.
- I agree to have the child stay in the general area for fifteen (15) minutes after receiving the vaccination. This is to watch for any reaction that may occur right away. We can't ensure that immediate reactions will not occur. I agree to take the child to their regular doctor or seek emergent care if the child has any unusual or severe side effects. This is at my expense.
- The Ascension Borgess Notice of Privacy Practices gives you information about how we use and disclose medical information about you. By signing this form, you are acknowledging that a copy was made available to you.
- Per Michigan law I am aware that Ascension Borgess may test the child's blood for HIV (AIDS virus), Hepatitis, or other infectious diseases if a healthcare worker is exposed to the child's blood or body fluids during this vaccination process.
- Parent or guardian accepts responsibility for revaccination (two (2) doses administered at least one (1) month apart are recommended for children who are receiving influenza vaccine for the first time or who received their first dose last year but did **NOT** get their second booster dose).

X _____

Signature of person authorized to make this request for above child.

Relationship to child receiving vaccine

Date

Time