2020-2021 Inactivated Influenza Vaccination Consent Form - Drive Through State Employee Clinic

Version 09/01/2020

1) Do not attend the clinic if you do not feel well.
2) Review the separate Vaccine Information Statement.
3) **Fully complete** and **SIGN** the consent form **BEFORE YOU ARRIVE**. (1 form per person)
4) If an answer to any question 1 - 4 below is YES, you will be refered to your medical provider for vaccination.
5) Wear clothing that allows easy access to the upper arm (upper thigh for infants and preschoolers).
6) Everyone in the vehicle over age 2 yrs. should WEAR A FACE MASK.
7) Check the BHR State Sponsored Clinic schedule for street entrance. Watch for signs & for staff directing traffic.
8) Plan to wait in the designated area for 15 minutes after vaccination.
9) Restroom facilities will not be available. Please plan accordingly.

The South Dakota Immunization Information System (SDIIS) is an automated system to document vaccinations given in South Dakota. SDIIS will give parents access to their child's immunization record from any participating South Dakota provider. SDIIS also allows providers to send reminder notices regarding needed immunizations. Health care providers, health care facilities, federal or state agencies, welfare agencies, school or family day care facilities may have access to this information in accordance with applicable HIPAA Privacy Act standards and requirements. Immunization records remain confidential, and any person who fails to protect this information is guilty of a Class 1 misdemeanor. If you choose not to have the record of this immunization shared with other providers, you may request a refusal form.

Information about person to be vaccinated (please print)

Last Name _____ First Name _____ Sex _____M ____F

Date of Birth:_____ Phone # _____ Mailing Address _____

City _____ Zip _____ (If Child) Parent's name _____

State of SD Health Plan NUMBER :_____ **Group ID:** _____

Two digit number on insurance card reflecting covered individual: (e.g. 01, 02.) _____

For a Dependent Covered by SD Health Plan: Name of Policy Holder _____

Policy Holder Date of Birth _____ Relationship _____

	Yes	No	Don't Know
1) Is the person sick today? _____			
2) Does the person have an allergy to eggs or to a component of the vaccine?			
3) Has the person ever had a serious reaction to influenza vaccine in the past?			
4) Has the person ever had Guillain-Barré syndrome? _____			

I have had access to the Vaccine Information Statement and have read or have had explained to me the information about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

Signature _____ **Date** _____

Person to be vaccinated (If minor, parent or guardian signature)

If you need proof of vaccination - please bring your cell phone to take a picture of the consent after vaccination.

for office use only

	Type	Date/Time	Vaccine Manufacturer (Circle)	Vaccine Lot number	Dose	IM Site (Circle)	Date of VIS Publication	Full Signature of person administering vaccine
INFLUENZA	IIV4		Sanofi Pasteur GlaxoSmithKline		0.5 mL	L R Deltoid Thigh	8-15-2019	

Abbreviation Key: **IIV4** - Inactivated Influenza Vaccine, Quadrivalent **IM** - Intramuscular **L** - Left **R** - Right

Clinic

Assessment of vaccination history for child under age 9

_____ Child will need 2nd dose

_____ Additional information needed