Consent for Influenza for **Individuals 6 Months to 18 Years of Age**

DHD Immunizations Clinic
100 Mack Ave. Detroit, MI 48201

Client Name: _____Birthdate: _____/_____/_____Sex: M F

Parent/Guardian Name: _____

Street Address: _____ City: _____State: _____ Zip: _____

Phone Number (preferred): _____ cell home other

	Yes	No
1. Is the child sick today?		
2. Does the child have allergies to medications, food, a vaccine component, or latex?		
3. Has the child ever had a serious reaction after receiving a vaccine		
4. Does the child have long term health problems with heart disease, lung disease (including asthma), immune system, neurologic disease, metabolic disease (diabetes), kidney disease, liver disease?		
5. Does the child have anemia, a blood disorder, bleeding disorder or take anticoagulant medication (blood thinner)?		
6. Has the child ever had Guillain-Barre Syndrome (temporary severe muscle weakness) within 6 weeks of receiving flu vaccine?		

_____ _____
Parent/ Guardian Signature Date

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered and VIS Given	Route	Site (Circle One)	Dose	Vaccine Manufacturer	Lot Number	Date of VIS
Influenza		IM	LA RA LT RT	0.5 mL			08/06/2021

Eligibility Status: Private VRP

Signature and Title of Vaccine Administrator: _____ Date: _____

Notes:
