2020-2021 INACTIVATED INFLUENZA CONSENT FORM **POD** 08/31/2020

1) Review the separate Vaccine Information Statement.
2) Fully complete and sign this form **BEFORE** arriving at the POD.
3) Review questions 1-12 below.
   If any answer is YES: **DO NOT ATTEND THE POD EVENT**

CLINIC:
Mitchell Area POD
604 N Main St.
Mitchell SD 57301

4) Traffic or parking directions? Other site specific directions?
5) Face Masks are REQUIRED to enter the POD. Those not wearing a face mask will not be allowed to enter.
6) Clinic flow will facilitate social distancing, please respect directions and signs.
7) Wear clothing that allows easy access to the upper arm (upper thigh for infants and preschoolers).
8) Plan to wait 15 minutes after vaccination in the designated area.

Information about person to be vaccinated *(please print)*

Last Name:_____ First Name _____ Sex _____M ____F

Date of Birth:_____ Phone # _____ Mailing Address _____

City _____ Zip _____

For child - Please Print

Parent's Name:_____

DO NOT ATTEND THE POD if any answer is YES	**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?			
5) Fever or chills?			
6) A new cough, shortness of breath, or difficulty breathing?			
7) New headaches, new muscle or body aches, unusual fatigue?			
8) New loss of taste or smell?			
9) A new sore throat?			
10) Nausea, vomiting, or diarrhea?			
11) Exposed within the last two weeks to someone positive for COVID-19?			
12) Positive for COVID-19 and waiting to be released from isolation?			

I have had access to the Vaccine Information Statement 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 completing form for a child at a school-based POD that you will not accompany, please provide a phone number where you can be reached on the date/time of the clinic:
(Phone number) _____

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

For children under age 9: _____ **Child needs 2nd Dose** _____ **Assess if child needs second dose**