2022-2023 INACTIVATED INFLUENZA CONSENT FORM Mitchell Area POD 8/2022

Review carefully before arriving at the POD

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

1) Stay home if you do not feel well
2) Complete and sign this form BEFORE arriving at the POD.
3) A limited number of people will be allowed into the clinic at one time
4) You may need to wait in the parking lot for a signal to enter
5) Face Masks are optional.
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:_____ AGE: _____ Phone # _____

Mailing Address _____ City _____ Zip _____

For child - Please Print

Parent's Name:_____

	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) Cough, shortness of breath, or difficulty breathing?			
7) Headaches, muscle or body aches, unusual fatigue?			
8) New loss of taste or smell?			
9) Sore throat, congestion, or runny nose?			
10) Nausea, vomiting, or diarrhea?			
11) Recently exposed to, or caring for someone positive for COVID-19?			
12) Positive for COVID-19 in the last 30 days?			

I have been provided a copy of and have read or have had explained to me the information about influenza and the vaccine listed below. 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 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	10/18/2022	Sanofi Pasteur OTHER? GlaxoSmithKline		0.5 mL	L R Deltoid Thigh	8-6-2021	

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

for children: office use only _____ **Child needs 2nd Dose** _____ **Assess if child needs second dose**