

Fisherville Pharmacy Influenza Vaccine Consent Form CHILD

****THIS BOX IS FOR PHARMACY USE ONLY****

Adhere RX Vaccine Label Info Here

Vaccinator's Initials

Patient Information (Vaccine Recipient):

Name		Date of Birth		Gender
Address			Estimated Weight	
City	State	Zip	Phone Number	
State of Birth:		Mother's Maiden Name:		
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other		

Screening Questions:

Question	YES	NO	Don't Know
1. Are you feeling ill today, or have you been ill within the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had a serious reaction after receiving a vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, please provide details: _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Preservatives such as thimerosal or phenol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had Gullian-Barre Syndrome, a neuro-muscular condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have a bleeding disorder or are you taking a blood thinner (warfarin, daily aspirin)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you taken antiviral medications in the past 2 weeks [including: (zanamivir) Relenza®, (oseltamivir) Tamiflu®, (peramivir) Rapivab, or (baloxavir) Xofluza]?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you received a vaccine in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. If your child is between 6 months to 8 years old is this their first flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Consent:

I have read on behalf of my child, the written information regarding the vaccine(s) being administered. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet. I, on behalf of my child, hereby agree to release, indemnify, and hold harmless Fisherville Pharmacy, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s). I hereby give my consent to the vaccinators of Fisherville Pharmacy to administer the vaccine(s) to my child. I agree to have my child wait near the vaccination location for approximately 15 minutes for observation by the vaccinator. I understand that if my child experiences any side effects, it will be my responsibility to follow-up with their primary provider's office or at the health center of my choice. By authorizing the administration of the vaccine(s), I also authorize the release of this information to my child's primary care provider.

NH Immunization Information System-The New Hampshire Immunization Information System is a secure statewide vaccine registry that connects and shares immunization information among public clinics, private provider offices, and local health care facilities that administer immunizations and provide medical care to New Hampshire residents. By signing below, you are agreeing to Fisherville Pharmacy sharing this information to the New Hampshire immunization information system. Under state law you do have the opportunity to opt-out of the immunization registry on your child's behalf if you wish to do so. Please request the opt-out form directly.

NHIS Opt In Opt Out

Parent or Guardian's Signature: _____ Date: _____