Ely-Bloomenson Community Hospital
328 West Conan St.
Ely, MN 55731
218-365-3271 | www.ebch.org

CONSENT FORM FOR INFLUENZA SHOT (CHILD/TEEN UNDER 18)

PLEASE PRINT CLEARLY

CHILD'S LAST NAME: _____

CHILD'S FIRST NAME: _____ MIDDLE INITIAL: _____

CHILD'S DATE OF BIRTH: _____ AGE: _____

GUARDIAN NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE NUMBER: _____

PARENT/LEGAL GUARDIAN CONSENT FOR VACCINATION: I have read or had explained to me the 2020-2021 vaccine information statement for the seasonal influenza vaccine and understand the risks and benefits and have been allowed to ask questions and answers were given to my satisfaction. As **a PARENT/LEGAL GUARDIAN**, I give consent to Ely-Bloomenson Community Hospital and its staff to vaccinate my child with this vaccine. My signature serves as verification that I have the legal authority to sign.

SIGNATURE: _____ DATE: _____

PLEASE NOTE: In an effort to monitor influenza immunization levels among community members and health care workers across the state, the flu vaccination you receive and your provided information will be recorded in the Minnesota Immunization Information Connection (MIIC), the statewide registry. Information in MIIC is confidential and will only be shared with organizations or persons authorized by law to receive it. If you do not want to participate in the registry, please call 1-800-657-3970.

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

For Patients (both children and adults) to be vaccinated: the following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	YES	NO	UNSURE
1. Is the person to be vaccinated sick today?			
2. Does the person to be vaccinated have an allergy to a component of the vaccine?			
3. Has the person to be vaccinated ever had a severe reaction to the influenza vaccine in the past?			
4. Has the person to be vaccinated ever had Guillain-Barre´syndrome?			

Name & Title of vaccine administrator: _____

Form Reviewed: NO _____ YES _____

VACCINE	ROUTE	DATE ADMINSTERED	VACCINE MANUFACTURER	LOT NUMBER	EXPIRATION
Fluzone-Quad	IM		Sanofi Pasteur		
Fluzone-Quad	IM		Sanofi Pasteur		