MONUMENT HEALTH

* E C O N O T H *

Community Influenza Consent Inactivated Injectable 2020/2021

*** Required**

Information about person to be vaccinated *(please print)*	**For office use only**
***Last Name:** _____	Notes: _____
***First Name:** _____ ***Sex:** ☐ M ☐ F	_____
***Date of Birth:**_____	_____
Address:_____	_____
City/State: _____ Zip: _____	
Phone Number: _____	

Has the person ever been to a Monument Health facility? ☐ Yes ☐ No

***Please answer the following questions for the person being vaccinated.**	**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 influenza vaccine?			
3. Has the person ever had a serious reaction to influenza vaccine in the past?			
4. Has the person ever had Guillain-Barre` Syndrome?			

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. I understand and I consent that information about my vaccinations will be shared with the South Dakota Department of Health who maintains a database of vaccinations.

Signature:** _____ ***Date:**_____Time:** _____

For Office Use Only:

INFLUENZA

Type	**Vaccine Manufacturer**	**Vaccine Lot Number**	**Vaccine Expiration Date**
☐ **IIV4 -** Inactivated Influenza Vaccine, Quadrivalent ☐ _____	☐ ID Biomedical ☐ Sanofi Pasteur ☐ Seqirus	☐ N97L7 ☐ P7HK7 ☐ _____	☐ 06/27/21 ☐ 06/30/21 ☐ _____

Route	**VIS Publication**	**Date/Time**	**Site**	**Signature of Person Administering Vaccine**
Intramuscular	08/15/2019		☐ Left Deltoid ☐ Right Deltoid ☐ _____	