|  |  |  |
| --- | --- | --- |
| Are you sick today? | Yes\_\_\_\_\_\_\_ | No\_\_\_\_\_\_\_\_ |
| Do you have an allergy to chicken eggs, gentamicin, gelatin, arginine, thimerosal, neomycin, polymyxin, or latex? | Yes\_\_\_\_\_\_\_ | No\_\_\_\_\_\_\_\_ |
| Have you ever had a serious reaction to a flu shot? | Yes\_\_\_\_\_\_\_ | No\_\_\_\_\_\_\_\_ |
| Have you ever had Gullain-Barre’ Syndrome or any other neurological disease?  In the past 12 months have you been treated for wheezing or had a recent diagnosis of Asthma? | Yes\_\_\_\_\_\_\_  Yes\_\_\_\_\_\_\_ | No\_\_\_\_\_\_\_\_  No\_\_\_\_\_\_\_\_ |
| Would you like to receive a copy of the Health Department’s privacy notice? | Yes\_\_\_\_\_\_\_ | No\_\_\_\_\_\_\_\_ |

**Consent**

I have read the information on the appropriate Vaccine Information Statement (VIS). I am informed of the benefits and risks of the vaccine(s) that will be given today. I grant permission for vaccines(s) to be administered to myself or the person whom I am authorized to sign as their parent or guardian.

I have had an opportunity to receive a copy of the Wayne County Health Department’s Notice of Privacy Practices.

I grant permission for this record to be released to my medical provider, school, day care center, WIC, other health department, and the state immunization registry, as is required or necessary.

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Signature of Legal Custodian/Client Date

**For Health Department Nurse Only**

\_\_\_\_\_ Immunization history has been reviewed to determine the vaccines which are indicated for the

child.

\_\_\_\_\_ Screening questionnaire was reviewed, and no contraindications to the above vaccines have been

found.

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RN Signature