COLE COUNTY HEALTH DEPARTMENT
INFLUENZA IMMUNIZATION CONSENT AND SCREENING

Patient Name: _____ Date: _____ F: ☐ M: ☐

Birth Date: _____ Age: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s)" for the vaccine(s) myself or the person named above will be receiving today. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) currently due for which I have signed below be given to me or the person named above for whom I am authorized pursuant to Section 431.058 RMSo to make this request.

Signature: _____ Self: ☐ Parent: ☐ Guardian: ☐ Designee: ☐

**Rarely a severe reaction to an immunization occurs. Everyone is screened before receiving any immunization for this reason. If a severe reaction is going to occur it usually occurs within 15 minutes of receiving the immunization. For this reason we ask everyone to wait 15 minutes after receiving an immunization before leaving the building. If you have no problems after this time you may leave.

SCREENING QUESTIONNAIRE			
Are you currently ill or do you have a fever?	**☐YES**	**☐NO**	**☐Unknown**
Do you have allergies to medication, food or any vaccine?	**☐YES**	**☐NO**	**☐Unknown**
Have you had a reaction to a vaccine before?	**☐YES**	**☐NO**	**☐Unknown**
Any intussusception, a seizure, brain problem or Guillain-Barre Syndrome?	**☐YES**	**☐NO**	**☐Unknown**
Do you have any chronic health issues (diabetes, heart disease)?	**☐YES**	**☐NO**	**☐Unknown**
Are you pregnant or could become pregnant in the next month?	**☐YES**	**☐NO**	**☐Unknown**

**********DO NOT WRITE BELOW THIS LINE**********

Date Given: _____ Vaccine: _____ Lot #: _____

Exp. Date: _____ Stock: _____ SITE: RD ☐ LD ☐

RN Review/Vaccine Administered by/VIS given: _____