Dignity Health
Chandler Regional Medical Center
CRMC Community Wellness
1955 W. Frye Rd. Chandler, Az. 85224

Appointments at:
www.dignityhealth.org/chandlerimmunizations
Masks are required for entrance.
Please bring a ballpoint pen for personal use.
If you or your child, had symptoms in the past 24 hours of: Fever, body aches, fatigue, cough, sore throat, shortness of breath, headache, sudden loss of smell or taste, nausea or diarrhea , please delay your visit.

CHILD Consent for Influenza (Flu) Vaccine

PRINT NAME LEGIBLY

FIRST NAME:_____ **DATE OF BIRTH:**_____
LAST NAME:_____ **MIDDLE NAME:**_____
GENDER/SEX:_____**AGE:**_____**PHONE:**_____
ADDRESS:_____**CITY:**_____**ZIP:**_____
LEGAL GUARDIAN NAME:_____
MOTHERS MAIDEN NAME:_____

MARK ONE:

(0) _____ is enrolled in **Kids Care**?
(1) _____ is enrolled in **AHCCCS**? Which plan? _____
(2) _____ **does NOT have** health insurance
(3) _____ is American Indian or Alaskan Native
(4) _____ has private insurance that **does NOT cover** the Flu vaccine
(5)_____has private insurance **that covers** the Flu vaccine

I have been given a copy and have read or have had explained to me the CDC "**Vaccine Information Sheet" for Influenza (flu) Vaccine dated 8/06/21**. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the Influenza Vaccine and request that it be given to me.

Signature of parent or guardian:_____

Effective April 14, 2003 the law requires that **Chandler Regional Medical Center** give to a patient a copy of its Notice of Privacy Practices for Health Information. This notice describes how medical information about you may be disclosed and how you can get access to this information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, you acknowledge receipt of such as the patient, the patient's personal representative, the patient's authorized agent, or an individual involved in the patient's medical care.

Signature of parent or guardian:_____ **Date:**_____

PLEASE ANSWER THE FOLLOWING:

- Do you have a fever or acute infection at the present time? ☐ **YES** ☐ **NO**
- Have you had any of these kinds of symptoms in the past 24 hours? ☐ **YES** ☐ **NO**
  - Fever, body aches, fatigue - cough, sore throat, shortness of breath
  - Headache, sudden loss of smell or taste - Nausea or diarrhea
- Are you allergic to eggs? ☐ **YES** ☐ **NO**
- Allergy to Thimerosal (a preservative in contact lens solution)? ☐ **YES** ☐ **NO**
- Have you ever had a serious reaction to a previous dose of the flu vaccine? ☐ **YES** ☐ **NO**
- Do you have a history of Guillain-Barre Syndrome (a neurological disorder)? ☐ **YES** ☐ **NO**

ADMINISTRATIVE USE ONLY

DATE VIS & Vaccine-given	FUNDING	VACCINE	MANUFACTURER/ LOT #	ROUTE	SITE	REVIEWED AND ADMINISTERED BY
		IIV4		IM		

Revised DEC 2020