2018-2019 Worksite Vaccination Consent Form

Kandiyohi County Health and Human Services,
2200 23rd St NE, Suite 1080
Willmar, MN 320-231-7800 Fax: 320-231-7888

For office use only:
☐Flu ☐Tdap ☐Hep B
Clinic site: _____

Information about person to receive vaccine (Please Print)

Name: Last	First	MI	Date of Birth Month Day Year
Under age 18 only: Parent/Guardian Name			Age Gender ☐ M ☐ F
Address:			Doctor Clinic
City	State	Zip Code	School-*under age 19 only* Grade Level

Primary Insurance:	Secondary Insurance:
ID # Group # Person's relationship to policy holder: ☐ Self ☐ Spouse ☐Child	ID# Group # Person's relationship to policy holder: ☐ Self ☐ Spouse ☐Child

►EVERYONE must answer these questions

Yes	No	
☐	☐	Are you sick today?
☐	☐	Do you have a life-threatening allergy to eggs?
☐	☐	Do you have a life-threatening allergy to thimerosal (preservative found in some vaccines and some eye/ear solutions)?
☐	☐	Have you ever had a serious reaction to a previous dose of influenza vaccine?
☐	☐	Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?

I GIVE CONSENT for me/my child to be vaccinated. I have received the Vaccine Information Statement for each vaccine and understand the risks and benefits. I hereby request that Kandiyohi County Health and Human Services administer the vaccinations. I hereby forever release Kandiyohi County Health and Human Services, its agents, employees, officers, and the County of Kandiyohi for any illness, injury, loss or condition I/my child may suffer, including death, due to the administration of these vaccines. I have been informed and I understand that the vaccine I/my child will receive may not be effective in all people and may not in fact protect me/him/her from the disease it is intended to prevent. I understand that the information contained within this record is being maintained to monitor immunization needs in order to prevent disease. This information is confidential and will only be shared with organizations or persons who are authorized by law to receive it. This includes the Minnesota Department of Health, a health care provider or health care organization providing services on behalf of me/my child, the child's school or childcare and anyone else authorized under law to receive it. This information will be included in the Minnesota Immunization Information Connection Registry, a secure web-based registry system for health care providers. If you choose not to have your information shared with registry please call 1-800-657-3970.

Signature of person to receive vaccine or, in the case of a minor child, the person authorized to make the request (i.e., parent, child's representative, or legal representative).

**Vaccination will not be administered if this consent form is not signed and dated*

*Sign: _____ Date: _____

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Flu Vaccine Administered	Dose/Route	Injection Site	VIS Date
	IM ☐ .25cc (6-35 mo.) ☐ .5cc (36 mo+)	RD LD RT LT	8-7-15

Signature of Nurse(s) Adm. Vaccine: _____ Date administered/VIS given:_____

Vaccine Administered	Dose/Route	Injection Site	VIS Date
☐Tdap Sanofi/GSK ☐Hep B GSK Lot #(s)	IM	RD LD	Tdap 2-24-15 Hep B: 7-20-16