Influenza Immunization Health Assessment and Consent Form for Children

Child's Last Name(s) _____ Child's First Name(s) _____

Date of Birth _____ Daytime Phone # _____

Age Category:

☐ 6 mths - < 2 yrs ☐ 2 - <5 yrs ☐ 5 – 17 yrs

Name of person completing the form	Relationship to child: ☐ Parent ☐ Guardian ☐ Other

I acknowledge that I have the authority to consent on behalf of the above named child and I consent to have the North Bay Parry Sound District Health Unit staff administer the influenza vaccine to this child.

Signature _____ **Date** _____

HEALTH ASSESSMENT – PLEASE ANSWER ALL OF THE QUESTIONS BELOW

	Yes	No	N/A
Is the child feeling well today?	☐	☐	☐
Has the child had the influenza vaccine before?	☐	☐	☐
Has the child had any reactions to any previous vaccines he/she has received?	☐	☐	☐

Is the child allergic to any of the following:

☐ Neomycin ☐ Polymyxin B ☐ Thimerosal (Contact lens solution)

Is the child taking any of the following medications:

☐ Antibiotics for an infection
☐ Immune-suppressive drugs
☐ Coumadin or other blood thinners
☐ Theophylline

High Risk Criteria – please indicate all that apply

☐ 6months to < 5yrs of age
☐ Individuals with neurologic or neurodevelopmental conditions
☐ Individuals with underlying health conditions (eg: cardiac/pulmonary disorders, renal disease, morbid obesity, diabetes and cancer or weakened immune systems)
☐ Indigenous Peoples
☐ Household contacts of those at high risk or babies < 6 months
☐ Persons who provide child care to kids less than 5 years of age

This information is collected under the authority of the Health Promotion and Protection Act and the Personal Health Information Protection Act. This information may be shared with your health care provider upon their request. Questions regarding the collection of this information may be directed to the Vaccine Preventable Diseases Program, North Bay Parry Sound District Health Unit, 345 Oak Street West, North Bay, Ontario 1-800-563-2808 / 705-474-1400.

----------STOP HERE----------

For Health Unit Staff ONLY

Administered under the authority of Dr. J. Chirico, following MED–VPD-060 Quadrivalent Influenza Vaccine, FluLaval-Tetra, Fluzone and Afluria Tetra

☐ Informed Consent Obtained

Date given YYYY/MM/DD Time given _____

Dose & Route 0.5 ml IM Site: ☐ Lt deltoid ☐ Lt thigh ☐ Rt deltoid ☐ Rt thigh Lot # _____

Indicate which dose was administered for children who have never had a flu vaccine ☐ Dose 1 ☐ Dose 2

Vaccine tolerated ☐ Well ☐ Faint ☐ Other

Nurse's Signature and Designation:

2019-11-29

☐ **General Population** ☐ **High Risk Client**