ACMC HEALTH

Influenza Vaccination Clinic Consent Form

Return to school one week prior to clinic date.

FOR INTERNAL USE
Reception _____
Central Reg _____
Scanned _____

Information About Child to Receive Vaccine: ***(Please print.)***

Child's Name – Last	First	M.I.

Child's Date of Birth: Month _____ Day _____ Year _____	Child's Gender Male / Female

Child's Doctor's Name

Child's Clinic

Mother's Maiden Name

Grade	Teacher

Parent's/Legal Guardian's Name - Last	First	M.I.

Address

City	State	Zip

Parent/Guardian Daytime Phone

1

Complete all blanks.

Screening for Vaccine Eligibility ***Please mark YES or NO for each question.***

The answers to the following questions will help us to determine if you can get the vaccine offered today.	***YES***	***NO***
Does your child have a SEVERE allergy to chicken eggs?	☐	☐
Has your child had a severe reaction to an influenza vaccination?	☐	☐
Has your child been diagnosed with Guillain-Barré syndrome (GBS) within 6 weeks of getting an influenza vaccine?	☐	☐

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Consent for Child's Vaccination:

I have read or had explained to me the 2017-2018 Vaccine Information Statement for the influenza vaccine and understand the risks and benefits.
I give consent to ACMC and its staff/volunteers for my child named at the top of this form to be vaccinated with the injectable Influenza vaccine.

Your signature below is required in order to vaccinate your child.

Signature of Parent/Guardian_____Date:_____

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Sign and date.

Please be sure to complete both sides

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Child's Name	Date of Birth:

Insurance Information

Insurance Company Name:		Subscriber's/Policy Holder's Name:
Insurance Claims Address:		Subscriber's/Policy Holder's Date of Birth:
ID Number:	Policy or Group Number:	Subscriber's/Policy Holder's Phone Number:
Medical Assistance Number:		

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Complete all blanks.

MINNESOTA VACCINES FOR CHILDREN PROGRAM (MnVFC) - PATIENT ELIGIBILITY SCREENING RECORD (Children 18 years of age or younger.)

Your child qualifies for vaccination through the MnVFC program because he/she:

Please √ only one box.	MnVFC Eligibility Criteria
	Uninsured
	Enrolled in MN Healthcare Program (MA, PMAP, GAMC, MnCare)[1]
	American Indian or Alaskan Native
	None of the above

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Please √ only one box.

*Underinsured patients are no longer eligible for MNVFC. Please check your insurance for coverage, you may be billed. You may also receive your vaccinations at local public health immunizations clinics.

)

Please be sure to complete both sides