

School Flu-Shot Clinic Registration

School / Facility: _____

Teacher's Name (If applicable): _____

Patient Information

Last Name: _____

First: _____

Date of Birth: _____

Age: _____

Mailing Address: _____

City: _____

State: _____

Zip: _____

Legal Sex: Male Female Preferred Language: _____

Parent/Guardian Information

Last Name: _____

First: _____

Relationship: _____

Phone: _____

Email: _____

Insurance

Not Applicable; Does not have health insurance coverage.

Medical Insurance	
Insurance Company Name or Medicaid: _____	
Policy Holder Name: _____	Policy Holder's Date of Birth: _____
Policy or Medicaid ID #: _____	Group # (If applicable): _____

- If you have immunization questions and would like to consult with a nurse directly, please call our shot line at 208-321-2229.

Please read and sign below to indicate consent

- *Vaccine Information Statements are information sheets produced by CDC that explain both the benefits and risks of vaccines. They can be found at cdc.gov/vaccines/hcp/vis.*
- *Participation in and withdrawal from Idaho's Immunization Reminder Information System (IRIS) is voluntary. I may call Idaho Immunization Program at 208-334-5931 to opt-out or withdraw. If I do not opt-out of IRIS in writing, my immunization records will be stored in the registry.*
- *I acknowledge that I have been given the opportunity to review the Consent for Services form, accessible via the QR code provided.*
- *By signing this form, I consent to receive services in accordance with these policies.*
- *By signing below, I give permission for my child to receive their flu shot without a parent / legal guardian present.*



**Consent for
Services**

 Dependent Patient Full Name

 Parent/Guardian Signature

 Date

Ada & Boise County

 707 N. Armstrong Pl. Boise, ID 83704
 208-375-5211

Elmore County

 520 E. 8th N. Mountain Home, ID 83647
 208-587-4407

Valley County

 703 1st St. McCall, ID 83638
 208-634-7194

Screening Checklist for Contraindications to Injectable Influenza Vaccination

For patients (both children and adults) to be vaccinated:

The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer “yes” to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Patient Name: _____

Date of Birth: _____

	Yes	No	I Don't Know
1. Is the person to be vaccinated sick today?			
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?			
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?			
4. Has the person to be vaccinated ever had Guillain Barré Syndrome?			
5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?			
6. Is the person to be vaccinated anxious about getting a shot today?			

Form completed by _____ Date _____

Did you bring your Immunization Record card with you? **Yes** **No**

It is important to have a personal record of your child’s vaccinations. If you don’t have one, ask the child’s healthcare provider to give you one with all your child’s vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

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