Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH

Ron DeSantis
Governor

Scott A. Rivkees, MD
State Surgeon General

Vision: To be the Healthiest State in the Nation

Influenza Consent Form

FluMist ☐ **(K – 5 ONLY)** Injectable ☐ **(6th-12th grades)**

Fill in the Grey areas only PLEASE PRINT - To be used only when consenting for **self** or for **when parent is consenting for minor.**

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Race: _____ Male Female

Address (Street): _____ City: _____ State: _____ Zip Code: _____

Phone #: _____ Social Security Number: _____-_____-_____

Please answer the following questions:

Are you a minor? (under the age of 18)	YES	NO
Are you allergic to eggs, egg products, or Thimerisol?	YES	NO
Have you ever had a severe reaction to any vaccine?	YES	NO
Do you have any neurological disorders such as Guillain-Barre Syndrome or MS?	YES	NO
Do you have a cold, fever, or other active illness?	YES	NO

I do hereby consent to Florida Department of Health in Suwannee County, located at 915 Nobles Ferry Road, Live Oak, FL, 32064, and any physician or health care provider or authorized agent examining or treating me to use or disclose protected health information for treatment, payment or health care operations including release to any third-party payer. This includes records on psychiatric/psychological treatment, alcohol/drug abuse, sexually transmitted diseases, tuberculosis, AIDS, HIV and case management information, including any information received from other health care provider concerning diagnosis and treatment.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THE ABOVE AND ACKNOWLEDGE RECEIPT OF THE NOTICY OF PRIVACY PRACTICES.

X_____ DATE:_____
Signature of person to receive vaccine or person authorized to make request.

SECTION BELOW TO BE COMPLETED BY PARENT/GUARDIAN FOR CHILD UNDER 18

I have read or have had explained to me the Vaccine Information Statement(s) for influenza vaccine. 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 I request that the vaccine be given to the patient named above for which I am authorized to make this request.

I, _____, have the following relationship with the person above:

Father Mother Stepfather Stepmother Court ordered legal guardian
Grandfather Grandmother Adult Aunt Adult Uncle Adult Brother Adult Sister

I have the legal authority, based on my relationship to the person indicated above, to consent to this vaccine.

_____ _____
Signature of Parent/Guardian Date

Vaccine MFG: _____ Lot #: _____ Exp Date: _____ Inj site: _____ Route: _____

Vaccination site: ☐ CHD ☐ SCHOOL ☐ Other: _____ VIS Date: _____

_____ Title: _____ Date: _____
Signature of representative who administered vaccine

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PHAB Accredited Health Department
Public Health Accreditation Board