2020-2021 State Employee Influenza Clinic

CLINIC: Spearfish BHSU

1) Review the separate Vaccine Information Statement.
2) **Fully complete and sign** this form BEFORE arriving. (1 form per person)
3) Review questions 1-12 below

If an answer to questions 1, 2, or 3 is YES, you will be referred to your medical provider for vaccination.

If an answer to a question 4 thru 12 is YES, access to the clinic will be denied as a COVID-19 precaution

4) **Face Masks are REQUIRED.** Bring your own masks for adults and school aged children
5) Clinic flow will facilitate social distancing; please respect directions and signs
6) Wear clothing that allows easy access to the upper arm (upper thigh for infants and preschoolers)
7) Plan to wait 15 minutes after vaccination in the designated area.

Information about person to be vaccinated (please print)

Last Name _____ First Name _____ Sex _____M ____F

Date of Birth:_____Age:_____ Phone# _____ Mailing Address _____

City _____ Zip _____(If Child) Parent's name _____

State of SD Health Plan NUMBER :_____ **Group ID:** _____

Two digit number on insurance card reflecting covered individual: (e.g. 01, 02.) _____

For a Dependent Covered by SD Health Plan: Name of Policy Holder _____

Policy Holder Date of Birth _____ Relationship _____

DO NOT ATTEND THE CLINIC IF any answer is YES	**Yes**	**No**	**Don't Know**
1) Does the person have an allergy to eggs or to a component of the vaccine?			
2) Has the person ever had a serious reaction to influenza vaccine in the past?			
3) Has the person ever had Guillain-Barré syndrome?			
4) Is the person sick today?			
5) Fever or chills?			
6) A new cough, shortness of breath, or difficulty breathing?			
7) New headaches, new muscle or body aches, unusual fatigue?			
8) New loss of taste or smell?			
9) New sore throat?			
10) Nausea, vomiting, or diarrhea?			
11) Exposed within the last two weeks to someone positive for COVID-19?			
12) Positive for COVID-19 and waiting to be released from isolation?			

I have had access to the Vaccine Information Statement and have read or have had explained to me the information about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

Signature _____ **Date** _____

Person to be vaccinated (If minor, parent or guardian signature)

If you need proof of vaccination - please bring your cell phone to take a picture of the consent after vaccination.

for office use only

	Type	Date/Time	Vaccine Manufacturer (Circle)	Vaccine Lot number	Dose	IM Site (Circle)	Date of VIS Publication	Full Signature of person administering vaccine
INFLUENZA	IIV4	10/19/2020	Sanofi Pasteur GlaxoSmithKline		0.5 mL	L R Deltoid Thigh	8-15-2019	

Abbreviation Key: **IIV4** - Inactivated Influenza Vaccine, Quadrivalent **IM** - Intramuscular **L** - Left **R** - Right

For child under age 9: _____ **Needs 2nd Dose** _____ **Assess if child needs second dose** (8/2020)