YUMA DISTRICT HOSPITAL & CLINICS

Influenza Vaccine Consent Form and Administration Record

2024-2025 Season

- VFC
- Employee
- Other

RECEIVED WITH CLINIC VISIT ☐
RECEIVED WITH HOSPITAL VISIT ☐
HIGH DOSE VACCINE GIVEN ≥65 years old ONLY ☐

Information about person to receive vaccine (Please Print)

Name: _____ **Date of Birth** _____

Last First MI

Address: _____ **Sex: Male Female**

City: _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Doctor:** _____

I have read or have been explained to me the Vaccine Information Statement 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 influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. (parent or guardian)

X_____ **Date:** _____

- **Medicare**
- **Medicaid**
- **Other Insurance**

Please circle your answer to the following questions:

1. Have you received flu vaccine before? Yes No
2. Did you have problems with previous flu shots? Yes No
3. Are you ill today? Yes No
4. Do you have allergies to eggs or to Thimerosal Mercury? Yes No
(a medication preservative)? (Please answer "NO" to an egg allergy if you CAN eat foods with egg in them.)
5. Do you have a history of Guillian-Barre Syndrome (a paralysis problem)? Yes No

For Clinic Use Only

Clinic Site: AKRON CLINIC YUMA CLINIC YDH **VIS Date:** 08/06/2021

Date Vaccine Administered: _____ **Dose Given:** 0.25ml 0.5ml

- ☐ Fluzone HIGH DOSE 24-25 Sanofi Lot #UT8454BA / UT8463CA or _____ Exp. 06/30/2025

- ☐ Fluzone PF Trivalent 24-25 Sanofi Lot #UT8434JA / U8500BA or _____ Exp. 06/30/2025

Site of IM injection: RDT or LDT or _____

Signature and title of vaccine administrator: _____

Nurse comments: _____

Age Group	Dosage Schedule
9 years & older	0.5 ML: 1 dose
3-8 years	0.5 ML: 1 dose, If this is the child's first time receiving the vaccine, the child NEEDS a booster in 1 month.
6-35 months	0.25 ML: 1 dose If this is the child's first time receiving the vaccine, the child NEEDS a booster in 1 month

Yuma Clinic: 1000 West 8th Avenue Yuma, CO 80759 970-848-3896
Akron Clinic: 82 Main Street Akron, CO 80759 970-345-6336

Yuma District Hospital: 1000 West 8th Avenue Yuma, CO 80759 970-848-5405

YUMA DISTRICT HOSPITAL & CLINICS

Consentimieto de Vacuna de Influnza y Registro de Administración

Temporada 2024-2025

- VFC
- Employee
- Other

RECEIVED WITH CLINIC VISIT ☐
RECEIVED WITH HOSPITAL VISIT ☐
HIGH DOSE VACCINE GIVEN ≥65 years old ONLY ☐

Información de persona recibiendo vacuna (Por favor Imprima)

Nombre: _____ **Fecha de Nac.** _____

Apellido Nombre Inicial

Dirección: _____ **Genero: Masculino Femenino**

Ciudad: _____ **Estado:** _____ **Codigo Postal:** _____

Teléfono #: _____ **Medico:** _____

He leído o se me ha explicado la información sobre vacunación de la gripe y la vacuna contra la gripe. He tenido la oportunidad de hacer preguntas que fueron respondidas satisfactoriamente. Entiendo los beneficios y riesgos de la vacuna contra la influenza y pido que me la administren a mí o a la persona nombrada anteriormente por quien estoy autorizado a hacer esta solicitud. (padre o tutor)

X_____ **Fecha**: _____

- **Medicare**
- **Medicaid**
- **Otro Seguro Med.**

Por favor responda las siguientes preguntas:

1. Ha recibido la vacuna de influenza antes? Si No
2. Tuvo complicaciones con vacunas previas de influenza? Si No
3. Esta enfermo hoy? Si No
4. Tiene alergia al huevo o al Timerosal Mercurio? Si No
(un conservativo de medicamentos)? (Por favor responda "NO" a alguna alergia al huevo al SI poder comer alimentos conteniendo huevo.)
5. Tiene historial de Sindrome Guillian-Barre (un problema de parálisis)? Si No

Solo Para el Uso de Clínica

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