

2014 - 2015 Flu Vaccination Consent Form

姓	名	中間名的字母

住址 (家號碼和街名)	公寓(房間)號碼

城市	郵政編碼	性別 <input type="radio"/> 男 <input type="radio"/> 女

區號	電話號碼	出生日期 (例如 05/18/1980)
母親的名子		月 日 年

人種 / 種族 亞洲人 黑人 / 非洲美國人 拉美裔/拉丁美洲人 白種人 其它
 選擇其中之一 夏威夷原住民 / 亞太 美國印第安人 / 阿拉斯加原住民 多種 - 種族

1) 您今天是否有發高燒或身體不舒服?	<input type="radio"/> 是 <input type="radio"/> 否
2) 您是否也許或正在懷孕當中?	<input type="radio"/> 是 <input type="radio"/> 否
3) 您是否對流感疫苗有嚴重的過敏反應而需要藥物來控制?	<input type="radio"/> 是 <input type="radio"/> 否

我同意接種疫苗	十八歲以下須填寫父母或監護人姓名
簽名	

4) Do you have a severe allergy to eggs?	[If YES, See Egg Allergy Guidelines]	<input type="radio"/> Yes <input type="radio"/> No
5) Do you have an allergy to thimerosal?		<input type="radio"/> Yes <input type="radio"/> No
6) Do you have an allergy to latex?	[If YES, Do NOT Administer GSK - Fluorix]	<input type="radio"/> Yes <input type="radio"/> No
7) Have you ever had Guillain-Barré Syndrome (GBS)?		<input type="radio"/> Yes <input type="radio"/> No
8) Have you received any of these vaccines in the last 4 weeks?	[MMR, Varicella, LAIV, Shingles]	<input type="radio"/> Yes <input type="radio"/> No
9) Do you have any of the following medical conditions?	[If YES, Administer IIV ONLY]	<input type="radio"/> Yes <input type="radio"/> No
Heart, Lung, Kidney, or Liver Disease; Asthma; Cancer; Metabolic disease (i.e. diabetes); Blood Disorders (i.e. leukemia, lymphoma, sickle cell disease); Immune System Disorder (i.e. HIV / AIDS, steroid therapy)		
10) Is the person to be vaccinated between 2-49 years old? (Verify Age) *	[If NO, Administer IIV]	<input type="radio"/> Yes <input type="radio"/> No

If the vaccination is for a child, ask these questions:	[If YES to either, Administer IIV ONLY]
11) If child is < 5 years, have they been diagnosed with wheezing in the last 12 months?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
12) Is child taking long term medicine therapy containing ASPIRIN?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
13) For persons under 19 years, select VFC eligibility. (choose one)	<input type="radio"/> Uninsured <input type="radio"/> Medi-Cal / CHDP <input type="radio"/> American Indian / Alaskan Native <input type="radio"/> Not VFC eligible

Flu Vaccine VIS Date: 08/19/2014	Manufacturer and Lot Number	Dosage	Site	Initials
<input type="radio"/> INACTIVATED Flu Shot <input type="radio"/> LIVE Nasal Spray	Manufacturer <input type="radio"/> GSK <input type="radio"/> MI <input type="radio"/> NOV <input type="radio"/> SP	<input type="radio"/> 0.25 mL <input type="radio"/> 0.50 mL <input type="radio"/> 0.20 mL	<input type="radio"/> LD <input type="radio"/> RD <input type="radio"/> LT <input type="radio"/> RT <input type="radio"/> Intranasal	Admin. by
DOSE # <input type="radio"/> 1 <input type="radio"/> 2	Lot Number			[] [] []

Date Administered (ex. 10/30/2014) [] [] / [] [] / [] [] [] <small>Month Day Year</small>	* REMINDER LAIV Is Only For Healthy Clients 2 Thru 49 Years Of Age, Who Are NOT Pregnant
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