## Maricopa County Department of Public Health Consent for Immunization
## PLEASE PRINT

First Name: _____ Last Name: _____ Phone Number: _____

Street Address: _____ City: _____ Zip Code: _____

Male □ Female □ Date of Birth: Month _____ Day _____ Year _____ Age: _____

Insured for vaccines? No □ Yes □ Name of Insurance:_____

**Office Only**

**ASIIS #: _____**

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

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.

1. Is the person to be vaccinated sick today? Yes □ No □
2. Does the person to be vaccinated have an allergy to a component of the vaccine? Yes □ No □
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? Yes □ No □
4. Has the person to be vaccinated ever had Guillain-Barré syndrome? Yes □ No □

**I agree to allow the health care provider giving vaccinations consent to release information about all vaccinations given to me to the Arizona State Immunization System (ASIIS), other health care providers and schools in order to avoid receiving unnecessary vaccinations and to provide information about which immunizations have been received. I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request.**

**I have been given a copy and have read, or have had explained to me, the information in the "Important Information Statement(s)" for the disease(s) and vaccine(s) checked below. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines requested and ask that the vaccine(s) checked below be given me.**

☐ **I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES (HIPAA)** ☐ **DO NOT ENTER THIS IMMUNIZATION DATA INTO ASIIS**

**PATIENT/GUARDIAN SIGNATURE: X**_____**PRINTED SIGNATURE: X**_____ **Date:** _____

**Staff only:**

Screener Signature: _____ Date:_____

Vaccine Administration**: Influenza VFC/VFA** □ **Influenza PPV** □ **Site:** _____ **Nurse Signature**:_____

Vaccine Label: [redacted] **or** Lot# _____ Expiration date: _____ Manufacturer: _____ NDC#_____