North Carolina Immunization Registry

HealthPark Pediatrics

YOU MUST COMPLETE ALL FIELDS BELOW.

Information collected on this form will be used to document authorization for receipt of vaccine(s).

Patient's Name (Last, First, Middle Initial)

Date of Birth (mm/dd/yyyy) | Gender ☐ Male ☐ Female | Ethnicity (Check One) ☐ Hispanic ☐ Non-Hispanic

Race (Check all that apply)

☐ Asian ☐ American Indian or Alaskan Native ☐ White ☐ Unknown
☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race

Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial) | Relationship to Patient

Address | P.O. Box

City | County | State | Zip Code

Email Address (if applicable) | Home Telephone Number ( ) | Work Telephone Number ( ) | Extension

PLEASE ANSWER ALL OF THE FOLLOWING:

There are two kinds of flu vaccine. Your answers below will help us know which of the two kinds of vaccine your child can receive.

1. Has the patient ever had the season flu vaccine before? ☐ YES ☐ NO
   If not and the child is <9 years of age, it is recommend to get 2 doses of the flu vaccine this year at least 4 weeks apart.
2. Has the patient had a fever within the last 24 hours? ☐ YES ☐ NO
   If yes, we recommend rescheduling vaccine for a different date.
3. Has the patient ever had a SEVERE reaction to eggs or to any vaccines? ☐ YES ☐ NO

THE FOLLOWING QUESTIONS ARE FOR NASAL FLU VACCINES ONLY:

4. Does your child have asthma or any other chronic disease of lungs, heart, kidneys, liver, nerves or blood? ☐ YES ☐ NO
5. Does your child have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer? ☐ YES ☐ NO
6. Does your child have close contact with a person who needs care in a protected environment (e.g. someone who is going through chemotherapy)? ☐ YES ☐ NO

I am authorized by the parent, guardian, or person standing in loco parentis of the above-named child to obtain needed immunizations for the child.

I/parental designee have received the "Vaccine Information Statements" (VIS) about the disease(s) and vaccine(s). I have had a chance to review the VIS(s) and to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request the vaccine(s) indicated below to be given to me or the person named above for whom I am authorized to make this request.

SIGNATURE – Person to receive vaccine or person authorized to sign on the patient's behalf

X

Date Signed

FOR OFFICE USE ONLY:

Eligibility: ☐ American Indian/Alaskan Native ☐ Medicaid ☐ Not Insured ☐ Underinsured ☐ NC Health Choice ☐ Insured

Vaccine	Trade Name	Lot #	VIS Pub. Date	Date VIS Presented	Body Route	Body Site*	mL.
Influenza	Fluarix		08/15/2019		IM	RV LV RD LD	
Influenza	Flumist		08/15/2019			Intranasal	

* RV = Right Vastus Lateralis LV = Left Vastus Lateralis RD = Right Deltoid LD = Left Deltoid BN = Bilateral Nares RN = Right Naris LN = Left Naris

SIGNATURE AND TITLE – Person Administering Vaccine

Date Vaccine Administered