GREATER PORTLAND HEALTH

CARING FOR THE WHOLE COMMUNITY

Pediatric Influenza Registration and Consent Form

Last Name:_____ **First Name**:_____

Date of Birth:____/_____/_____

1. Is your child sick today?	Yes	No
2. Does your child have any allergies to medications, food, a vaccine component, or latex?	Yes	No
If yes, please list: _____		
3. Has your child had a serious reaction to a vaccine in the past?	Yes	No
4. Has your child had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, or a blood disorder?		
Is he/she on long-term aspirin therapy? If yes, please list: _____	Yes	No
5. If the child to be vaccinated is between the ages 2 and 4 years, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	Yes	No
6. If your child is a baby, have you ever told he or she has had intussusception?	Yes	No
7. Has your child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	Yes	No
8. Does your child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes	No
9. In the past 3 months, has your child taken medications that weaken their immune system, such as cortisone, prednisone, other steroids, or anticancer drugs or had radiation treatments?	Yes	No
10. In the past year, has your child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes	No
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	Yes	No
12. Has your child received any vaccinations in the past 4 weeks?	Yes	No

Consent for children under 18 years of age only:

Parent/Guardian Full Name: _____ Relationship: _____

Parent/Guardian Date of Birth: ___/____/_____

I have received the vaccine information sheet and agree to have the Influenza vaccine administered to my child.

Patients Parent/Guardian Signature:_____**Date:**_____

Clinical Staff Use Only:

Vaccine Name:	Date Administered:	Lot Number:	Exp. Date:	Manufacturer:	Site Administered at:	Administered By:

Patient Name:_____ **Date of Birth:**____/_____/_____

Please complete if not already an established GPH Patient

Mailing Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Phone Number:** _____

Birth Sex (Gender): _____

Preferred Language: _____ **Do you need an interpreter?**_____

Insurance Information:

Primary Insurance Carrier (please circle one): MaineCare Anthem/BCBS Cigna Community Health Options Medicare Harvard Pilgrim United Healthcare Aetna Uninsured

Other: _____ Primary Care Practice: _____

Policy Number: _____ Group Number: _____