Advocate Children's Hospital

CHICAGOLAND & NORTHWEST INDIANA

Ronald McDonald Care Mobile

Advocate Children's Hospital 1675 W. Dempster St. Park Ridge, IL 60068 (847)723-7358

Influenza Vaccine Consent

Name: _____ Date of Birth: _____ Sex: _____ Race: _____

Address: _____City/State: _____ Zip Code: _____

Parent/Guardian _____ Home/Cell Phone Number: _____

Does your child have Medicaid/Kid Care Insurance? Yes___ No___

Private Insurance? Yes____ No____ If yes, does your insurance pay for vaccines? Yes____ No ____

Screening Questionnaire for Influenza Vaccinations

For parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give your child influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions may be asked. If a question is not clear, please ask the healthcare provider to explain it.

	Yes	No	Don't know
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 the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?			
Does your child/teen have an allergy to eggs or any part of a vaccine?			
Has your child/teen ever had a serious reaction to influenza vaccine in the past?			
Has your child/teen ever had Guillain-Barre syndrome?			
Has your child/teen had 2 previous "flu" vaccines since 2010?			
Has your child/teen received vaccinations in the past 4 weeks?			

(from www.immunize.org)

Patient Agreements and Authorizations

VACCINE INFORMATION: I have received and read the vaccine information statement "Inactivated Influenza Vaccine 2017-18." http://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf

CONSENT FOR TREATMENT: I hereby consent to the treatment provided by Advocate Physicians, Nurses or other designated health care providers. I understand that Physicians, Nurses and other health care providers in training may, under the supervision of appropriate personnel, participate in my child's treatment and I consent to such student involvement in my care.

DISCLAIMER: This Ronald McDonald Care Mobile is made possible by a grant from the Ronald McDonald House Charities, Inc. ("RMHC"), a non-profit, tax-exempt charitable corporation. RMHC has no responsibility or liability for the operation of this Ronald McDonald Care Mobile or any of the medical or dental activities conducted herein.

I want my child to have a seasonal flu vaccine.

Patient/Guardian Signature: _____ **Date:** _____

To be completed by Ronald McDonald Care Mobile staff

Reviewed by _____ Need to repeat in one month? Yes No

Flu vaccine type _____Manufacturer _____ Lot _____Site_____

Signature and title _____ Date _____

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