

Youth Clinic FLU WAIVER

Please select your preference:	
<input type="checkbox"/> Live Vaccine FluMist Nasal Spray	<input type="checkbox"/> Inactivated Vaccine Injection

STEP ONE:

The Vaccines for Children program, or VFC, is a Federal Program that purchases vaccines for children in certain eligibility groups. The vaccines are administered by participating physicians for the cost of the administration fee.

By marking the appropriate eligibility requirement below and signing in the space provided, you signify that your child meets at least one of the following requirements;

- Is currently eligible for Medicaid
- Have no health insurance (including catastrophic coverage)
- Is American Indian or Alaska Native
- None of the above**

X Signature of responsible party _____ Date _____

To Be Filled Out by Provider Office	
Patient Name _____	DOB _____
Provider _____	Date _____
<p>A record must be kept in the healthcare provider's office that reflects the status of all children 18 years of age or younger, who receive immunizations through the VFC program. This record may be completed by the parent, guardian or individual of record, or by the healthcare provider. The same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of response is not required, it is necessary to retain this record for each child receiving vaccine.</p> <p style="text-align: center;">To Be Retained in Patient Chart</p>	

STEP TWO:

I have read the information contained in the relevant CDC (VIS) sheet about influenza and I have had a chance to ask questions. I understand the benefits and risks of influenza and I authorize and request that the vaccine be given.

Initial for receipt of CDC information _____ **X**

Information of Person Receiving Vaccine	
Patient Name _____	Date of Birth _____ Age _____**
Parent Signature _____ (person receiving vaccine or parent/guardian)	Date _____

** People nine years and older need one shot each influenza season. Children less than nine years may need a second shot after one month.

For Clinic Use Only	
<u>FluMist</u>	<u>Injectable</u>
Date of Vaccination _____	Date of Vaccination _____
Manufacturer _____ MedImmune, Inc	Manufacturer _____ Aventis
Administration Site _____ nasal spray	Dose and Site _____
Nurse Initials _____	Nurse Initials _____
Lot # _____	Lot # _____