



**Dignity Health**

Chandler Regional Medical Center  
CRMC Community Wellness  
1955 W. Frye Rd. Chandler, Az. 85224

## CHILD Consent for Influenza (Flu) Vaccine

Appointments at:

[www.dignityhealth.org/chandlerimmunizations](http://www.dignityhealth.org/chandlerimmunizations)

Masks are required for entrance.

Please bring a ballpoint pen for personal use.

If you or your child, had symptoms in the past 24 hours of:  
Fever, body aches, fatigue, cough, sore throat, shortness of  
breath, headache, sudden loss of smell or taste, nausea or  
diarrhea , please delay your visit.

**PRINT NAME LEGIBLY**

**FIRST NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

**LAST NAME:** \_\_\_\_\_ **MIDDLE NAME:** \_\_\_\_\_

**GENDER/SEX:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**LEGAL GUARDIAN NAME:** \_\_\_\_\_

**MOTHERS MAIDEN NAME:** \_\_\_\_\_

**MARK ONE:**

- (0) \_\_\_\_\_ is enrolled in **Kids Care**?
- (1) \_\_\_\_\_ is enrolled in **AHCCCS**? Which plan? \_\_\_\_\_
- (2) \_\_\_\_\_ **does NOT have** health insurance
- (3) \_\_\_\_\_ is American Indian or Alaskan Native
- (4) \_\_\_\_\_ has private insurance that **does NOT cover** the Flu vaccine
- (5) \_\_\_\_\_ has private insurance **that covers** the Flu vaccine

I have been given a copy and have read or have had explained to me the CDC “**Vaccine Information Sheet**” for Influenza (flu) Vaccine dated 8/06/21. I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the Influenza Vaccine and request that it be given to me.

**Signature of parent or guardian:** \_\_\_\_\_

Effective April 14, 2003 the law requires that **Chandler Regional Medical Center** give to a patient a copy of its Notice of Privacy Practices for Health Information. This notice describes how medical information about you may be disclosed and how you can get access to this information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, you acknowledge receipt of such as the patient, the patient’s personal representative, the patient’s authorized agent, or an individual involved in the patient’s medical care.

**Signature of parent or guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING:**

- Do you have a fever or acute infection at the present time?  YES  NO
- Have you had any of these kinds of symptoms in the past 24 hours?  YES  NO
  - Fever, body aches, fatigue - cough, sore throat, shortness of breath
  - Headache, sudden loss of smell or taste - Nausea or diarrhea
- Are you allergic to eggs?  YES  NO
- Have you ever had a serious reaction to a previous dose of the flu vaccine?  YES  NO
- Do you have a history of Guillain-Barre Syndrome (a neurological disorder)?  YES  NO

**ADMINISTRATIVE USE ONLY**

DATE VIS & Vaccine-given	FUNDING	VACCINE	MANUFACTURER/ LOT #	ROUTE	SITE	REVIEWED AND ADMINISTERED BY
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