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

	Influenza (Flu) or Covid-19	

Please Initial Vaccine Requested

CHILD Consent for Vaccine

PRINT CHILDS INFORMATION 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) _____ child is enrolled in **Kids Care**?
(1) _____ Child is enrolled in **AHCCCS**?
(2) _____ Child **does NOT have** health insurance
(3) _____ Child is American Indian or Alaskan Native
(4) _____ Child has private insurance that **does NOT cover** this vaccine
(5)_____Child has private insurance **that covers** this vaccine

I have been given a copy of the **"Vaccine Information Sheet" for Influenza (flu) Vaccine dated 8/06/21 and or the recipient and Caregiver Fact Sheet for covid.** I have had a chance to ask questions which were answered to my satisfaction. I understand the benefits and risks of the Vaccine and request that it be given to my child. I agree to have this vaccine recorded in the Arizona Immunization Information System.

Signature of 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 guardian_____ **Date:** _____

PLEASE ANSWER THE FOLLOWING for your child:

Do they have a fever or feel ill today? ☐ YES ☐NO
Have they ever had a serious reaction to a prior dose of vaccine or injectable medicine? ☐ YES ☐ NO
Do they have a bleeding disorder or are they taking a blood thinner? ☐ YES ☐ NO
Have they ever rec. a Covid-19 vaccine? ☐YES ☐NO
Do they have any allergies? ☐ YES ☐ NO
Are they allergic to eggs? ☐ YES ☐ NO
Do they have a history of Guillain-Barre Syndrome (a neurological disorder)? ☐ YES ☐NO
Have they received any blood or medication transfusions in the past12 months ? ☐ YES ☐ NO

DATE GIVEN VIS & ADMIN	VACCINE	MANUFACTURER/ LOT#	RT	SITE	REVIEWED AND ADMINISTERED BY
	IIV4		IM		
	COVID-19 </= 11yr		IM		
	COVID-19 12+ yr old		IM		

Revised JUNE 2023