South Central Public Health District
Prevent. Promote. Protect.

Twin Falls – 208.737.5980
Heyburn – 208.678.8221
Jerome – 208.324.8838
Gooding – 208.934.4477
Bellevue – 208.788.4335

INFLUENZA IMMUNIZATION REGISTRATION FORM

- PLEASE PRINT CLEARLY

Patient Last Name	Patient First Name	Date of Birth	☐ Male ☐ Female
Mailing Address	City	State	Zip Code
Phone Number	Parent/Guardian Name	Parent/Guardian Date of Birth	
Does the Patient have Insurance? ☐ YES ☐ NO	Name of Insurance Company	Identification Number	Group Number
Race: ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ Decline to Specify		**Ethnicity:** ☐ Non-Hispanic ☐ Hispanic/Latino ☐ Other ☐ Decline to Specify	

Adults and children with a history of ASTHMA should consult a healthcare provider before receiving the FluMist nasal spray vaccine.

		YES	NO	N/A
1.	**ASTHMA question:** If the child to be vaccinated is 2 through 4 years of age: Has a healthcare provider told you that the child had wheezing or ASTHMA in the past 12 months?	☐	☐	☐
2.	**ASTHMA question:** If the person to be vaccinated is 5 years of age or older with an ASTHMA diagnosis: Is the asthma currently well controlled?	☐	☐	☐
	Have you or your child received FluMist vaccine in previous years without problems?	☐	☐	☐
	Do you consent to receive FluMist for yourself or your child today?	☐	☐	☐
3.	Is the person to be vaccinated younger than age 2 years or older than age 49 years?	☐	☐	☐
4.	Is the person to be vaccinated sick today?	☐	☐	☐
5.	Does the person to be vaccinated have an allergy to an ingredient of the influenza vaccine?	☐	☐	☐
6.	Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
7.	Does the person to be vaccinated have a long-term health problem with lung disease (including asthma), heart disease, kidney disease, neurologic disease, liver disease or metabolic disease (e.g., diabetes)?	☐	☐	☐
8.	Does the person to be vaccinated have a) an open channel between the cerebrospinal fluid (CSF) and the mouth, throat, nose or ear or any other cranial CSF leak, or b) a cochlear implant, or c) an immunocompromising condition due to any cause (e.g., medication, congenital or acquired immunodeficiency, HIV infection, or a missing or non-functioning spleen [e.g., caused by sickle cell disease])?	☐	☐	☐
9.	Is the person to be vaccinated currently taking influenza antiviral medications, or have they taken any within the past 3 weeks?	☐	☐	☐
10.	Is the person to be vaccinated a child or teen age 6 months through 17 years and receiving aspirin or salicylate-containing medicine?	☐	☐	☐
11.	Is the person to be vaccinated pregnant or could they become pregnant within the next 4 weeks?	☐	☐	☐
12.	Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐
13.	Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐	☐	☐
14.	Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐	☐	☐

SIGN CONSENT on next page →

FINANCIAL, PRIVACY & MEDICAL SERVICES CONSENT

- **Full Policies:** Review our complete Financial Consent and Notice of Privacy Practices at www.phd5.idaho.gov.
- **Insurance Billing & Coverage:** SCPHD will bill your insurance provider as a courtesy. Coverage and payment cannot be guaranteed with all insurance plans. Uninsured patients will be billed directly.
- **TRICARE Policyholders:** Please present the Benefits Number located on the back of your ID card.
- **Vaccine Access for Children:** Under the Vaccines for Children (VFC) program, no child aged 18 or younger will be denied recommended vaccines due to an inability to pay.
- **Financial Responsibility:** You are ultimately responsible for all charges incurred. By receiving services, you authorize SCPHD to release necessary medical information for claim processing and assign all insurance benefits directly to SCPHD.
- **Support & Financial Assistance:** If you are uninsured, underinsured, or have billing questions, please contact our office for assistance.
- **Privacy & Information Sharing:** Please note that your insurance carrier may send Explanation of Benefits (EOB) and Protected Health Information (PHI) directly to the primary policyholder.
- **State Registry Reporting (IRIS):** Immunization records will be entered into the Idaho Immunization Reminder Information System (IRIS). Registry participation is voluntary; instructions for record removal are available through the Idaho Department of Health and Welfare.
- **Vaccine Exemptions:** Vaccination is voluntary. Pursuant to Idaho Code § 39-4802, parents or legal guardians may submit official immunization exemptions directly to their child's school district.

PARENTAL PERMISSION & INFORMED CONSENT

- **Informed Consent & Shared Clinical Decision-Making:** I acknowledge that vaccine administration follows a shared clinical decision-making model. I have independently evaluated the risks, benefits, and indications for myself or my child through the provided CDC Vaccine Information Statement (VIS) or a primary healthcare provider. A SCPHD nurse will review this form the day of clinic to finalize the shared decision, and I grant permission for my child to receive the vaccine in my absence.

FluMist
Live, Intranasal Influenza Vaccine
(age 2 through 49 yrs old)

Injectable Flu
Inactivated Influenza Vaccine
(age 6 months and older)

- **Legal Authorization & Certification:** By signing below, I consent to receive medical services for myself or my child. Under penalty of perjury, I certify that I am the legal parent or authorized guardian of the minor receiving care.

Signature: _____ **Date:** _____

FOR OFFICE USE ONLY

Vaccine	Site	Lot #	Vaccine	Site	Lot #
FluMist			Flublok		
Standard Flu			High Dose Flu		
			RC Flu		

Nurse Signature: _____ Date: _____

CSR Name: _____ School/Location: _____