NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

COMMUNITY HEALTH NURSING

INFLUENZA CONSENT FORM

Please fill out the following for the person being vaccinated today:

Patient Name: _____ Middle _____ Last _____
Phone: (_____) _____ Birth Date: _____ Age Today: _____
Mailing Address: _____ City/State/Zip Code: _____
Parent/Guardian Full Name: _____ Mothers Maiden Name: _____
☐ Medicaid / NV Check Up #: ☐ Uninsured (*If possible, attach $20 payment)

Questions for the person getting vaccinated today:

1. Is the person to be vaccinated sick today? If yes, what are their symptoms? ☐ YES ☐ NO
2. Has the person been vaccinated against influenza (flu) in the past? ☐ YES ☐ NO
3. Does the person have any allergies, such as latex? ☐ YES ☐ NO
   If yes, list what allergies:
4. Has the person ever had a serious reaction to a vaccine in the past? ☐YES ☐NO
   If yes, please explain:
5. Has the person ever had Guillain-Barre Syndrome in the past? ☐YES ☐ NO

CHN is required to ask the following questions according to state law: NRS 449.104

Race: (Check all that apply): ☐Choose not to disclose ☐ White ☐Black/African American ☐ Pacific Islander ☐American Indian/Alaskan Native ☐Asian ☐ Other

Ethnicity (Check one box): ☐Choose not to disclose ☐Hispanic/Latino ☐Not Hispanic/Latino

Sexual Orientation (Check one box): ☐Choose not to disclose ☐Straight or heterosexual ☐Bisexual ☐Gay, Lesbian, or homosexual ☐Other ☐Do not know

Birth Sex: (Check one box): ☐ Choose not to disclose ☐ Female ☐ Male ☐ Other

Gender Identity (Check one box): ☐Choose not to disclose ☐ Female ☐ Male ☐Genderqueer
☐Female-to-male/Transgender male/Trans man
☐Male-to-female/Transgender female/Trans woman
☐Additional gender category or other, please describe: _____

Preferred Pronouns (Check one box): ☐Choose not to disclose ☐She/her/hers ☐He/him/his ☐They/them/theirs
☐Additional pronoun category or other, please describe: _____

Read and Sign:

- I have received and understand the vaccine information statement(s) and I have had the opportunity to ask Questions for the immunization(s) to be administered to me or the person named above, for whom I am authorized to make this request.
- I agree to allow my immunization information, or the person named above, for whom I am authorized to make this request, to be stored and accessed by authorized users in "Nevada's WebIZ" computer system unless I indicate otherwise.
- In the event of needlestick injury or exposure to blood or bodily fluids, I also agree to have my blood tested for bloodborne bacteria or viruses that my result in disease, or the person named above, for whom I am authorized to make this request.

By signing this document, I declare that the above information is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Parent/Guardian signature required if under 18 years old

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For Office Use Only

☐ Influenza, P-Free (_____ 2025-2026 0.5mL sd syr) (6 months+)
☐ 317 Lot _____ Exp. _____ Site: IM Deltoid: Left Right
IM Thigh: Left Right

☐ Influenza, P Free (_____ 2025-2026 0.5mL sd syr) (6 months+)
☐ 317 Lot _____ Exp. _____ Site: IM Deltoid: Left Right
IM Thigh: Left Right

Administered by: _____ Date: _____

WebIZ#: _____