



Forma De Consentimiento Para influenza 2023-2024

Label	<u>Vaccine Funding Source</u> <input type="checkbox"/> Purchased <input type="checkbox"/> Vaccine For Children <input type="checkbox"/> Vaccine For Adult <input type="checkbox"/> State Grant Fund
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Consentimiento para vacuna, por favor firme:

He leído o se me ha explicado la información sobre vacunación para la vacuna contra la influenza estacional y entender los riesgos y beneficios . Doy mi consentimiento a Bay Area Community Health y su personal para administrar la vacuna contra la gripe. (Si no se firma este consentimiento , la vacuna no será administrada)

Firma y fecha del paciente o custodio _____

Provider Fill out the Following:

Age	Dosage	Provider Initial
Child 6 months - 35 months old (2 doses 4 weeks apart if they are receiving the Flu vaccine for the first time)	0.25 mL	
Children 6 months to 8 years old (2 doses 4 weeks apart if they are receiving the Flu vaccine for the first time)	0.5 mL	
Children 9 years and older receive 1 dose	0.5 mL	
Pregnant Patients- preservative FREE	0.5 mL	

Second dose recommended Yes No

ICD 10: Z 23

Ordering Provider: _____ **Date:** _____

MA, select appropriate vaccine to be administered. Please enter Flu vaccine if not on the list.

CPT Code / Funding Source	Lot Number	Vaccine type	Manufacturer Indication	Exp. Date

Injection Site: Right deltoid Left deltoid right vastus lateralis left vastus lateralis

Signature and title of Vaccine Administrator: _____

Date: _____