2020-2021 Influenza Vaccine Consent Form

Site: DPH6/IMMUNIZATION OFFICE

MUST PRINT CLEARLY AND FILL OUT ALL INFORMATION

Name (last):	(First):	(M.I):	Date of Birth: / /	Phone:
	Race (please circle all that apply: African American, White, American Indian, Asian, Alaska Native, Hawaiian/Polynesian		Ethnicity: ☐ Hispanic ☐ Non-Hispanic	Gender: ☐ Female ☐ Male
Street Address:			**INSURANCE: Y ___ N ___** **IF YES:** **Primary Card Holder: _____** **POLICY # _____** **GROUP # _____** **Medicaid / Peach Care #_____** **Medicare #_____**	
City:	State:	Zip Code:		
		Primary Language:		

Please mark YES or NO for each question.	**YES**	**NO**
1. Are you sick today?	☐	☐
2. Have you received an influenza vaccine this year?	☐	☐
3. Do you have an allergy to eggs?	☐	☐
4. Do you have any allergies to medications, other foods, vaccines, or latex? **Please list: _____**	☐	☐
5. Have you ever had a serious reaction to a previous flu vaccine or any vaccine?	☐	☐
6. Have you ever had Guillain-Barré Syndrome?	☐	☐
7. Do you have any of the following: asthma, diabetes, disease of the lungs, heart, kidneys, liver, nerves, or blood?	☐	☐
8. Are you on long-term or aspirin-containing therapy?	☐	☐
9. Do you have a weak immune system?	☐	☐
10. Are you pregnant? N/A☐	☐	☐
11. Are you 65 or older?	☐	☐

CONSENT FOR VACCINATION

I have read the information on the Vaccine Information Statement. I understand the risks and benefits.

I **GIVE** CONSENT to the East Central Health District to administer the Influenza vaccine to me. I understand that after I receive a flu vaccination, I should wait at least 15 minutes before leaving the site. If I choose not to stay, the East Central Health District will NOT be held liable for any problems that occur.

Your signature conveys consent for services, acknowledgement of HIPAA privacy information, access to the current influenza vaccine information statement as well as consent to share information necessary for billing. Your signature authorizes payment of medical benefits to the undersigned provider or supplier for services provided.

Signature : **X** _____

Relationship to client (please circle one): SELF Parent/Guardian Other:_____

Date: _____

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Vaccine Manufacturer	Lot Number	Expiration Date	Name and Title of Vaccine Administrator
Quadrivalent	/ /	IM RD LD				