PAGE COUNTY PUBLIC HEALTH

Date:___________

Influenza Vaccination Consent Form

First Name______________________________ **MI**_____ **Last Name** ______________________________
(Please print name)

Address____________________________________**City**____________________**State**______ **Zip**______

Phone: ___________________________ **Gender: M**___ **F**___ **Birth date**____/____/____

Physician: _____________________________**Address** ______________________________________
(If physician is not local)

Primary Insurance: _____________________________

Secondary Insurance: ___________________________

FOR THOSE ON MEDICARE PLAN B, PLEASE PRESENT YOUR CARD FOR VERIFICATION.

MEDICARE#: ____ ____ ____ - ____ ____- ____ ____ ____ ____- ____ **(please include the letter)**

Medicaid # (Title XIX):____

I have read the information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination.

Signature: ____________________________________

<u>For Office Use Only:</u>

Vaccine	Date Dose Administered	Route	Vaccine Manufacturer	Lot Number	Administered By
INFLUENZA	/ /	IM SITE:			

Paid: Cash or Check #

Bill To: ________________________

Make copies to screen your patients.

Patient name: ______________________ Date of birth: ___/___/___
(mo.) (day) (yr.)

Screening Questionnaire for Inactivated Injectable Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

Form completed by: ______________________ Date: __________

Form reviewed by: ______________________ Date: __________