ADULT

Annual Influenza Vaccine (Flu Shot) Consent Form

PLEASE PRINT! Circle choices

Patient's Name: _____ **Date of Birth:** _____

Race(s): White | African American/ Black | Native American / American Indian | Asian | Native Hawaiian / Pacific Islander

Is this patient Hispanic or Latino? YES NO **Gender:** Male Female

Address: **City/ZIP:** **Phone:**

SCREENING FOR VACCINE ELIGIBILTY: The following questions will help us to know if you can get the seasonal influenza vaccine. If you answer "NO" to all four of the following questions, you can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, you may be able to get the seasonal influenza vaccine, but we will contact you to discuss your options.

1. Do you have a serious allergy to eggs? ☐ YES ☐ NO
2. Do you have any other serious allergies? ☐ YES ☐ NO
3. Have you ever had a serious reaction to a previous dose of flu vaccine? ☐ YES ☐ NO
4. Have you ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine? ☐ YES ☐ NO
5. Are you pregnant? ☐ YES ☐ NO

Payment: _____ Private Insurance _____ Medicaid _____ NO Insurance

Policy Holder's Name: _____ **Date of Birth** _____

PLEASE ATTACH COPY OF CARDS OR COMPLETE INFORMATION BELOW:

Insurance Company:	Member/Policy Number:	Group Number:

Policy Holder's Contact Info (if different from above):

Address: **City/ZIP:** **Phone:**

CONSENT FOR VACCINATION: I have read or had explained to me the 2020-2021 Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

ASSIGNMENT OF BENEFITS: I understand that all services, including unpaid balances, are charged to the responsible party. Information will be provided to expedite insurance carrier payments. By signing below, I request that payment of authorized Medicare, Medicaid, or other insurance company benefits be made to Sheridan County Public Health. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

MONTANA STATE IMMUNIZATION DATABASE: I authorize my health care provider and a public health agency to collect and enter my immunization records into the Department of Public Health and Human Services' Immunization Information System (IIS).

Signature:_____ Date: _____

FOR ADMINISTRATIVE USE ONLY

ROUTE	SITE	DATE	INFLUENZA VACCINE MANUFACTURER / LOT #/ EXP	ADMINISTRATOR
IM				

Vaccine Administrators: Courtney Grove, RN ~ or ~ Martie Simonson, RN