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Seasonal Influenza Vaccination Consent/Administration Form

Patient's Name _____ _____ _____
(Last) (First) (Middle Initial)

Mailing Address _____

City_____ **State** _____**Zip** _____

Date of Birth _____ **Age** _____ **Gender** _____ **SS#** _____ **Race** _____
Month/Day/Year Male/Female (optional)

Home Phone # _____ **Cell Phone #**_____ **Work Phone #**_____

	Yes	No
Is the person to be vaccinated sick today?	☐	☐
Does the person to be vaccinated have an allergy to latex, mercury, thimerosal, gelatin, or other vaccine components?	☐	☐
Has the person to be vaccinated demonstrated an allergy to chicken products or eggs?	☐	☐
If yes, was there an anaphylactic reaction, i.e. facial swelling or difficulty breathing?	☐	☐
Has the person to be vaccinated ever had a serious reaction after receiving a vaccination?	☐	☐
Is this the first time the person to be vaccinated will receive the flu vaccine?	☐	☐
Does the person to be vaccinated have a chronic illness (such as asthma), a weakened immune system, or are they in direct contact with anyone who does?	☐	☐
Is the person to be vaccinated on long-term aspirin treatment?	☐	☐
Has a physician ever diagnosed the person to be vaccinated with Guillain-Barré Syndrome (GBS) or any other neurological disease?	☐	☐

PLEASE TURN PAGE OVER AND COMPLETE OTHER SIDE

HEALTH DEPARTMENT USE ONLY

HIGH DOSE	**FLUARIX**	**LOT NUMBER / EXPIRATION**	**STATE**
PEDIATRIC	**INTRADERMAL**	**INJECTION SITE:**	**PRIVATE**

_____ _____
Vaccinator's Signature **Date**

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

The JCHD Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice of Privacy Practices is subject to change. A copy of this notice is available upon request. By signing this form, you acknowledge that the JCHD Notice of Privacy Practices was made available to you.

CONSENT

(You must be at least 18 years of age to sign. If under age 18, a parent or guardian's signature is required.)
I voluntarily and of my own free will give consent to The Jefferson County Health Department medical staff to administer an influenza vaccination to me. I have been provided an Influenza Vaccine Information Statement. I have had an opportunity to ask questions and I understand the benefits and risks of the vaccination. I further understand that the JCHD will not be responsible for any adverse reactions to the vaccines.

PAYMENT INFORMATION

☐ **Self-pay - Cash, check, or credit card payments may be made on the day of the clinic.**

☐ **Bill Insurance – fill in your insurance information below.** I request that payment of authorized third party (including Medicare) benefits be made to Jefferson County Health Department for services furnished by the Department. Submission of insurance information does not guarantee coverage. I understand that if the insurance company does not cover the vaccine(s), I will be responsible for payment.

☐ **Bill Employer or other organization – complete separate billing consent form.**

PRIMARY INSURANCE: ☐ None Does your Primary Insurance cover immunizations? ☐ YES ☐ NO

Insurance Company Name: _____ Plan name: _____

ID Number: _____ Group Number (if any):_____

Policy Holder:_____ _____ _____ _____
(Last) (First) (Middle Initial) (Gender)

Policy Holder Birth Date _____ Relationship to Patient_____ SS # _____

Policy Holder Address (if different from patient): _____

Home Phone#_____ Cell Phone #_____ Work Phone # _____

SECONDARY INSURANCE: ☐ None Does your Secondary Insurance cover immunizations? ☐ YES ☐ NO

Insurance Company Name: _____ Plan name: _____

ID Number: _____ Group Number (if any):_____

Policy Holder:_____ _____ _____ _____
(Last) (First) (Middle Initial) (Gender)

Policy Holder Birth Date _____ Relationship to Patient_____ SS # _____

Policy Holder Address (if different from patient): _____

Home Phone#_____ Cell Phone #_____ Work Phone # _____

_____ _____
Patient/Patient Representative's Signature **Date**

Amount Paid	**Cash**	**Credit**	**Check #**
Receipt #	**Receipt issued by**		