Wyandot County Public Health
127- A South Sandusky Avenue
Upper Sandusky, OH 43351
Phone 419-294-3852 | Fax 419-294-6435
www.wyandothealth.com

Influenza Immunization Screening and Consent Form

PLEASE PRINT CLEARLY

Last Name _____ **First Name** _____ **M.I.** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone Number _____ **Parent/Guardian Name** (only if client is under age 18) _____

Birth Date _____ **Age** _____ **Sex** Male Female

Please answer the following questions:	**Circle One**	
Is the person to be vaccinated sick today?	YES	NO
Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	YES	NO
Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?	YES	NO
Has the person to be vaccinated ever had Guillain-Barré Syndrome?	YES	NO
Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?	YES	NO
Is the person to be vaccinated anxious about getting a shot today?	YES	NO

By signing below, I acknowledge that I have read (or have had explained to me) the information regarding Influenza disease and the Influenza vaccine. I had the opportunity to ask questions that were answered to my satisfaction and received a Vaccine Information Sheet. I understand the risk of the Influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I understand information regarding my vaccine may be transferred to the Ohio Department of Health Immunization Program. I acknowledge that I have been offered or received a copy of the notice of privacy practices for Wyandot County Public Health (WCPH). I give my consent to use and disclose my protected health information for the purposes of treatment and payment of my health care. My signature also displays my understanding that I am responsible to provide payment of all charges at the time of service.

Patient Signature (or Guardian) _____ **Relationship to Patient** _____

Date Signed _____

For Office Use Only

INSURANCE

Medicaid (ex.Traditional Medicaid, CareSource, Molina, Buckeye, Humana, Anthem, Amerihealth)

Insurance Name:_____ Member ID:_____

Primary / Secondary

Private Insurance (ex: Anthem, MMO, UMR,)

Insurance Name:_____ Member ID:_____

Primary / Secondary

Medicare: Member ID_____

Medicare Supplement:

Insurance Name: _____ Member ID:_____ HMO / PPO

Insurance copied	Insurance on file	VIS Date
Yes / No	Yes / No	1/31/2025

Staff initials

For Office Use Only

To be completed by nurse administering vaccine:

Date	Vaccine Name	Vaccine Lot #	Expiration Date	Manufacturer	IM Site	Dose	Staff initials
	Fluzone		*6/30/2026*	*Sanofi Pasteur*	LD / RD	**6 mos & older: 0.5mL**	

Children 6 months-8 years ONLY : ☐ Initial Dose ☐ Second Dose ☐ Previously Vaccinated

_____ I have reviewed the side effects with parent/guardian, as applicable.
_____ I confirm that the patient/guardian was given the opportunity to ask questions about the vaccination, and all questions asked by them have been answered correctly, and to the best of my ability.
_____ I have confirmed a VIS was offered and the patient has received a copy.
_____ I have confirmed the consent is signed and dated.
_____ I have reviewed the above questions and clarified any necessary information.

LVL / RVL

Temp:

65 years and older: 0.5mL High Dose

Circle One:

PRIVATE

VFC

Clinic Site: