

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

|                                                                                                  |                  |           |
|--------------------------------------------------------------------------------------------------|------------------|-----------|
| <b>INSURANCE</b>                                                                                 |                  |           |
| <b>Medicaid (ex.Traditional Medicaid, CareSource, Molina, Buckeye, Humana, Anthem, Ameritas)</b> |                  |           |
| Insurance Name: _____                                                                            | Member ID: _____ |           |
| Primary / Secondary                                                                              |                  |           |
| <b>Private Insurance ( ex: Anthem, MMO, UMR, )</b>                                               |                  |           |
| Insurance Name: _____                                                                            | Member ID: _____ |           |
| Primary / Secondary                                                                              |                  |           |
| <b>Medicare:</b> Member ID _____                                                                 |                  |           |
| <b>Medicare Supplement:</b>                                                                      |                  |           |
| Insurance Name: _____                                                                            | Member ID: _____ | HMO / PPO |

For Office Use Only

To be completed by nurse administering vaccine:

| Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Vaccine Name | Vaccine Lot # | Expiration Date | Manufacturer | IM Site | Dose                | Staff initials |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|---------------|-----------------|--------------|---------|---------------------|----------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Fluarix      |               | 6/30/2027       | GSK          | LD / RD | 19 & older<br>0.5mL |                |
| ____ I have reviewed the side effects with parent/guardian, as applicable.<br>____ 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.<br>____ I have confirmed a VIS was offered and the patient has received a copy.<br>____ I have confirmed the consent is signed and dated.<br>____ I have reviewed the above questions and clarified any necessary information. |              |               |                 |              |         |                     |                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |               |                 |              | Temp:   |                     |                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |               |                 |              |         |                     |                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |               |                 |              |         |                     | 317            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |              |               |                 | Clinic Site: |         |                     |                |