2019-20 INFLUENZA (FLU SHOT) CONSENT FORM

FOR CLINICAL USE ONLY

QUADRIVALENT	MANUFACTURER: LOT & EXPIRATION DATE:	
SITE OF INJECTION: R / L DELTOID DOSES: . 5CC R / L VASTUS LATERALUS DOSES: .25CC (#1 / #2) .5CC		
SIGNATURE & TITLE OF VACCINE ADMINISTRATOR:		Date:
PAYMENT: CASH $ CHECK$ # MEDICARE / MEDICAID		

----PLEASE COMPLETE PATIENT INFORMATION----

LAST NAME:	FIRST NAME:		MI:
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:
PHONE:	MEDICARE/MEDICAID NUMBER:		
BIRTHDAY:	AGE:	GENDER:	MALE / FEMALE CIRCLE ONE

	CIRCLE ONE
1. Do you have a severe allergy to eggs?	YES or NO
2. Have you ever had a life-threatening reaction to flu vaccine?	YES or NO
3. Do you have a history of Guillain-Barre Syndrome?	YES or NO
4. Are you moderately or severely ill today, with a high fever?	YES or NO

I have been offered a copy of the Vaccine Information Statement (VIS - 8/15/2019). I have read, or had explained to me, and understand the information in the VIS.
I ask that the influenza vaccine be given to me or to the person named below for whom I am authorized to make this request.
I consent to inclusion of this immunization data in the Kansas Immunization Registry (KSWebIZ) for myself or on behalf of the person named below.
I acknowledge that I have received/been offered a copy of Wabaunsee County Health Department's Notice of Privacy Practices effective January 7, 2016.

Signature ______________________________ Date ____________________

WABAUNSEE COUNTY HEALTH DEPARTMENT COURTHOUSE
215 KANSAS AVE - ALMA, KS 66401

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