CITY-COWLEY COUNTY HEALTH DEPARTMENT
FLU CLINIC CONSENT FORM

Name: LAST	FIRST		M.I.
Date of Birth / /	**Age**	**Gender** ☐Male ☐Female	
Address:	**City:**	**State:**	**Zip Code:**
Phone # ( ) -	**Alt Phone** ( ) -	**Email:**	

Is your primary phone a cell phone? ☐Yes ☐No
If so, may we leave voice or text messages from this office on your phone? ☐Yes ☐No

Race: ☐Black ☐White ☐ Asian ☐Native Am Other _____ **Ethnicity:** ☐Hispanic ☐Non-Hispanic ☐Unknown

1. Is the person to be vaccinated today currently sick? ☐Yes ☐No

2. Has the person to be vaccinated had a serious reaction to eggs or egg products? ☐Yes ☐No

3. Does the person receiving the vaccine have an allergic reaction to latex? ☐Yes ☐No

The cost of the influenza vaccination is $25.00/$75.00 - How would you like to pay for this today?

☐ Bill my insurance ☐ Bill me at the address listed above ☐ I will pay in full today ☐ Employer Sponsored

Primary Insurance Name:	**Relationship to Insured:**	
Insured's Name: LAST	FIRST M.I.	**Insured's Date of Birth** / /
Insurance Plan ID #	**Group #**	**Plan #**

The August 6, 2021 Vaccine Information Statement for the seasonal influenza vaccine has been offered to me and I understand the risks and benefits of the flu vaccine. I also have been offered the Notice of Privacy Practice. My questions have been answered satisfactorily and I ask that the vaccine be given to me or to the person named for whom I am authorized to make this request. I hereby authorize City-Cowley County Health Department, to release to my insurance company or its representative any information including the records of any treatment or examination rendered to me during my visit for care. I hereby authorize City-Cowley County Health Department to release all information necessary to secure payment for this treatment. I assign the medical payment benefits to which I am entitled, including Medicare, KanCare, private insurance, and any other health plan to City-Cowley County Health Department for payment of the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand and I (We) promise to pay for the services. I acknowledge that I understand these terms and that if I am unable to pay today that I can speak with a Health Department representative to make affordable payment arrangements.

Signature _____ **Date** _____

PROVIDER INFORMATION

CITY-COWLEY COUNTY HEALTH DEPARTMENT

320 E. 9th, Suite B
Winfield, KS 67156
620-221-1430

115 E. Radio Lane
Arkansas City, KS 67005
620-442-3260

To be completed by the vaccine administrator only:

FLU VACCINE

Injection Site:
LT Deltoid IM LT Vastus Lat. IM **Dose: 0.5 ml**
RT Deltoid IM RT Vastus Lat. IM **0.7 ml**

Manufacturer: Sanofi Pasteur Other _____

Lot #: _____ ☐ HD ☐ Flublok ☐ PFS ☐ MDV

Exp. Date: 6-30-23 **Exp.** _____

_____
Vaccine Administrator's Signature

Date Given:

OFFICE USE ONLY

Download Our App Today!

ANDROID APP ON Google play

Download on the App Store