Pottawatomie County Health Department

FLU VACCINE DOCUMENTATION AND CONSENT FORM

X Influenza Vaccine

VACCINE ELGIBITILITY (FOR OFFICE USE ONLY)

- ☐ VFC
- ☐ 317
- ☐ Private

PATIENT INFORMATION / INSURANCE INFORMATION

First Name: _____

Last Name: _____

Gender: M / F **Phone #:** _____

Birth Date: _____/_____/_____ **Age:** _____

Address: _____

_____

PLEASE MAKE SURE YOUR INSURANCE CARD WAS GIVEN TO THE RECEPTIONIST AND CHECK THE BOX BELOW THAT APPLIES TO THE PATIENT

☐ Medicaid 19 ☐ CHIP 21 ☐ No Insurance ☐ Under-Insured ☐Under-Served
☐ American Indian/Alaskan ☐ Medicare ☐ Fully Insured

As the client or parent/legal guardian, I understand I will be responsible to pay for any immunizations provided that Medicaid, Medicare, KanCare, Cigna, Tricare or any other private health insurance does not cover. Pottawatomie County Health Department is not an in-network provider for Cigna, TriCare, or Aetna. *Initials:* ____

IMMUNIZATION SCREENING QUESTIONNAIRE

1. Is the patient to be vaccinated sick today or experiencing a fever? If yes, please explain:	YES NO
2. Has the patient to be vaccinated ever had a life-threatening reaction to any food, medication, eggs or vaccine? (e.g., anaphylaxis, trouble breathing, hives) If yes, please list:	YES NO
3. Does the patient to be vaccinated have a severely weakened immune system due to illness or is the person currently receiving cancer treatments with radiation or drugs?	YES NO
4. Has the patient to be vaccinated ever had Guillain-Barré syndrome? (Symptoms start as weakness and tingling in the feet and legs that spread to the upper body.)	YES NO

By signing this form, I give consent to the above vaccine to be administered to me, or to the person named above, for whom I am authorized to make this request. I have been offered a copy of the Vaccine Information Statement (VIS) for the vaccine. I understand and am aware I am advised to wait for 15 minutes post vaccination for monitoring. I acknowledge that I have received a copy of the Pottawatomie County Health Department's Notice of Privacy Practices with the effective date of May, 20 2021. I consent to the inclusion of this immunization data in the Kansas Immunization Registry, Integrated Referral and Intake System (IRIS), and Data Application and Integration Solution for the Early Years (Daisey) system. I consent to the sharing of this immunization data with any licensed physician, our primary care provider, educational institutions and/or health insurance companies that request this information, on behalf of the person named above.

Signature of Patient or Legal Parent/Guardian: **Printed Name of Person Signing:** **Date:**

_____ _____ _____

VACCINE	DOSE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER, LOT #, EXPIRATION DATE
Influenza **Needs #2? Y N**	1 2	RT LT	Deltoid Vastus Lat	IM	8-6-21	
Influenza HD 65	1	RT LT	Deltoid	IM	8-6-21	SP

VACCINE ADMINISTRATOR

Signature and Title: _____ Date: _____

Time Vaccine Administered: _____ Time Client Out: _____