Wilson County Health Department
Influenza Vaccination Consent form

I have been offered or provided, whether accepted or not, a copy of the "Vaccine Information Statements" (VIS) for Influenza. I have read, or have had explained to me, the information in the "VIS". My questions have been answered satisfactorily and I ask that the Influenza vaccine be given to me or the person named below for whom I am authorized to make this request. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I acknowledge that a Notice of Privacy Practices is on file at the Health Department with the effective date of 4-14-2003 and that a copy will be made available to me if I so desire.

Patient's Last Name **Patient's First Name** **Age** **Date of Birth** **Grade**

Street Address **City** **County** **State** **Zip Code**

_____ ____**Male** ___**Female** _____

Home Phone Number **Physician**

Parent/ Guardian Signature _____

Insurance Information:

Wilson County Health Dept can bill various private insurance companies. If we do not have a contract with your insurance, there will be a fee of $20.00 for the flu shot. There will be a $20.00 fee for uninsured children. You may have to pay co-pays and co-insurance depending on your insurance plan. If you are unsure please call the Health Department.

Insurance Company: _____ **ID#**_____

Subscriber Name:_____ **Subscriber DOB**_____

Group #_____**Relationship to Subscriber:**_____

*******TURN OVER******* 

**Please Complete Screening Questionnaire **

The questions on this page will help us determine if there is any reason we should not give your child an influenza vaccination today. If a question is not clear, please ask your healthcare provider to explain it or **feel free to call the Wilson County Health Department (620) 378-4455**.

Screening Questions

	Yes	No
Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?		
Has the person to be vaccinated ever had a serious reaction to an influenza vaccine in the past?		
Is the person to be vaccinated currently pregnant?		

STOP!!!

**********HEALTH DEPARTMENT USE ONLY**********

Site: Left_____ Right_____ Delt _____ VL _____

Manufacturer: Sanofi Pasteur Lot #

Expiration Date:

VIS Date:

Signature and Title of Vaccine Administrator _____

Date: