PUBLICHEALTH
healthier together

OFFICE USE ONLY
Clinic Site _____

Medicaid- Active: AG ITC Inactive hawk-i: AG ITC BCBS UHC/UMR Medicare

0-18 VFC Eligibility (circle one): T-19 NI UI AI/AN Q Other: _____

2019-2020 FLU SHOT CONSENT FORM

2nd dose flu needed*: Yes No

1. Personal Information (Please Print Clearly):

NAME: _____ **BIRTH DATE:** ____/____/____
First Last MM DD YYYY

AGE: _____ **GENDER (circle):** Male Female **CELL PHONE:** (____)_____

PHONE: (____)_____ **STREET ADDRESS:** _____

CITY, STATE, & ZIP CODE: _____
(City) (State) (Zip)

2. Screening Questions:

Please answer the following questions (Check Yes, No or Don't Know):	Yes	No	Don't Know
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?			
Has the person to be vaccinated ever had Guillain-Barre syndrome after receiving a flu vaccine? **If you do not know what this is then you probably have never had it.**			
Has the person to be vaccinated received a vaccine anywhere else **TODAY**?			
Does the person to be vaccinated have an allergy to any component in the flu vaccine? **Components may include (circle all that apply): eggs, thimerosal, latex**			

3. Insurance & Consent for Administration of Vaccine:

Complete this section only if you do not have your insurance card(s) with you today.

Ins Co. Name: _____ **ID#:**_____

Policy Holder: _____**GRP#:** _____

I hereby assign Cerro Gordo County Public Health all benefits otherwise payable to me under the medical expense provision of any or all of my health insurance policies to satisfy my indebtedness to said clinic. I agree that, should the amount be insufficient to cover my entire medical expense or not covered by my policy contract, I will be responsible for payment of the difference/my deductible or entire bill. I further authorize Cerro Gordo County Public Health to furnish my health insurance company or its representatives any information pertaining to the medical treatment received at said clinic.

To my best knowledge, this information is factual. I have been offered the Influenza Vaccine Information Sheet (8/15/2019) and given the opportunity to ask questions which have been answered to my satisfaction. I understand the benefits and the risks of the vaccine. By signing below I give consent for the administration of the vaccine to myself or my child/dependent as printed on this form.

_____
Printed Name of Person Signing Consent (parent/guardian)

_____ _____
Signature of Patient or Parent/Guardian of Dependent **Date**

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Date	Site	Lot #	Nurse's Signature
	IM ( ) LD ( ) LT ( ) RD ( ) RT		

**Children 6 months through 7 years of age may need a 2nd flu vaccine. If they do, give 2nd dose flu vaccine post card reminder to parent/guardian and file this consent form in the 2nd dose flu folder in the Immunization Clinic.*

Date	Site	Lot # (circle vaccine given)	Nurse's Signature
	IM ( ) LD ( ) LT ( ) RD ( ) RT	Flu #2 PCV13 PPSV23	

Nurse Notes: _____

Super Bill:

BILL	VFC	CODE	INFLUENZA (all products are egg based)
☐	☐	90686	Fluarix (6 months and older)
☐	☐	90686	FluLaval PFS (6 months and older)
☐		90688	FluLaval MDV- 0.5mL (6 months and older)
☐		90653	Fluad (65 and older)
☐		90662	Fluzone High Dose (65 and older)
			PNEUMOCOCCAL
☐		90732	Pneumovax23 **Circle Presentation: Vial Syringe**
☐		90670	Prevnar13

IMMUNIZATION CLINIC ONLY:

Additional Vaccine Documentation (i.e. Tdap):

Date	Site	Lot # (circle vaccine given)	Nurse's Signature
	IM ( ) LD ( ) LT ( ) RD ( ) RT	Flu #2 Other: _____	