RICHD ADULT FLU CONSENT

FULL NAME: ______________________________

First Name M Last Name

DATE OF BIRTH: ____________ AGE: ______

STATE EMPLOYEE ONLY
STATE EMPLOYEE ONLY: YES_______NO_____
LAST 4 OF SS#________________

CIRCLE GENDER: MALE FEMALE

STREET ADDRESS: ______________________________ CITY: ________________

STATE: ________ ZIP CODE: ____________

CIRCLE RACE: WHITE BLACK/AFRICAN-AMERICAN ASIAN AMERICAN INDIAN OTHER: ______________

CIRCLE ETHNICITY: HISPANIC/LATINO NON-HISPANIC/LATINO

CIRCLE PREFERRED LANGUAGE: ENGLISH SPANISH OTHER

INSURANCE PRIMARY:____________________ID#________________GROUP#__________

SECONDARY:____________________ID#________________GROUP#__________

**Do you have any allergies? (eggs, chicken, latex or medicines)	Circle: YES NO
Have you ever had a **REACTION to a flu shot before:	Circle: YES NO
**Do you currently have an active illness or are your taking antibiotics?	Circle: YES NO
**Have you had Guillain-Barre Syndrome?	Circle: YES NO
**Have you traveled outside of the US within the last 30 days?	Circle: YES NO
**Have you been in contact with anyone who has traveled outside of US within the last 30 days?	Circle: YES NO

If you answer "yes" to any of the above questions, please let the nurse know

JOINT NOTICE OF PRIVACY PRACTICES GIVEN

I HAVE READ OR HAD THE INFORMATION ABOUT THE INFLUENZA VACCINE EXPLAINED TO ME. I WAS GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I UNDERSTAND THE BENEFITS AND RISKS OF THE INFLUENZA VACCINE AND REQUEST THE VACCINE BE GIVEN TO ME OR THE PERSON FOR WHOM I AM AUTHORIZED TO MAKE THIS REQUEST. I UNDERSTAND THAT THE IMMUNES GIVEN TODAY WILL BE ENTERED INTO THE STATE DATA BASE, UNLESS I DECLINE. THE LAST FOUR DIGITS OF YOUR SOCIAL SECURITY NUMBER IS SO THAT YOUR BILL WHEN SUBMITTED CAN BE READILY IDENTIFIED AND PAID.

X ______________________________

PRINTED NAMED

X ______________________________ ________________

SIGNATURE of person receiving vaccine or parent/guardian DATE

AGENCY USE ONLY PP STOCK ONLY

FLU VACCINE

SITE:______

2020-2021

VIS GIVEN:____

8/15/2019

LOT#__________

EXP DATE:__________

FLUBLOK:______

FLUZONE QUAD: ______

HIGH DOSE: ________

Office Use Only: BILLING
Clinic Site: ______________
Payment: ________ cash/check/cc#__________
Medicare _____ Private Insurance _____ IPA Adult___
Bill Township ________________
Bill County for Employee/dependent: ______
State Employee:______

SIGNATURE OF NURSE ADMINISTERING VACCINE:______________________________

9/4/2020