RICHD CHILD FLU CONSENT

FULL NAME: ____

First Name M Last Name

DATE OF BIRTH: ____________________ AGE: ________

CIRLCE GENDER

STREET ADDRESS: ______________________________________ CITY: ________________________

STATE: ________ ZIP CODE: ______________ PHONE NUMBER: ________________________

CIRCLE ETHNICITY: HISPANIC/LATINO NON-HISPANIC/LATINO

CIRCLE PREFERRED LANGUAGE: ENGLISH SPANISH OTHER

CIRCLE RACE: WHITE BLACK/AFRICAN-AMERICAN ASIAN AMERICAN INDIAN 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 <u>REACTION</u> 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

VFC

VFC FLUZONE QUAD 6-35MTHS (2YRS11MTHS):__________

PP

FLUZONE QUAD ______

VIS GIVEN_____

8/15/2019

LOT#__________

EXP DATE:__________

2020-2021_______

Office Use Only: BILLING

Clinic Site: ________________

Payment: ________ cash/check/cc#__________

Medicare _____ Private Insurance _____ IPA Child____

Bill Township ____________________

Bill County for Employee/dependent: _______

SIGNATURE OF NURSE ADMINISTERING VACCINE:______________________________

9/4/2020