Cash/Check/Insurance

Warren County Health Services
ADULT Consent for Influenza Vaccination

Please print the following information

Name: _____ Date: _____

Address: _____City: _____

State: _____Zip: _____ Phone: _____Date of Birth:_____

Gender: Male _____Female_____ Age: _____

<u>Medicare Number (if applicable)</u> Please include the "letter" following the number, must have Part B to qualify for flu vaccine re-imbursement_____

<u>OR</u>
Wellmark BC/BS or United Health Care <u>Insurance</u> _____ Member ID #_____ Group #_____

Card Holder Name _____Card Holder DOB:_____ Relationship to you_____

<u>OR</u>

A donation of $24 is suggested

1) Are you age 65 years or older? Yes No **In NO stop here**
2) Have you ever received the pneumonia vaccine? Yes No

I have read, or have had explained to me, the information about influenza disease and the influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccination and request vaccination to be administered to me, or the above named for whom I am authorized to make this request.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain right to privacy regarding my protected health information. The Notice of Privacy Practice has been made available to me, which explains these rights. Warren County Health Services Notice of Privacy Practice can be viewed online at: http://www.co.warren.ia.us/Health_Services/NOPP-HS.pdf . I authorize the release of medical or other information necessary to process billing claims. I authorize Payer to pay provider directly and agree to pay any co-pay, deductible, or amount not paid by insurance.

Signature: _____ Date: _____

For office use:
Site: RD LD Lot # _____ Manufactured by:

Administered by: _____RN Date:_____

Patient Name_____ Date of Birth____/_____/_____

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

		Yes	No	Don't Know
1.	Is the person to be vaccinated sick today?	___	___	___
2.	Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	___	___	___
3.	Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	___	___	___
4.	Has the person to be vaccinated ever had Guillain-Barre syndrome?	___	___	___

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4066.pdf • Item #P4066 (9/17)