Public Health
Prevent. Promote. Protect.

VFC/Cash/Check/Insurance

Child Flu Consent for Vaccination

Please print

Child's Full Name: _____ Date of Birth: _____ Age: _____ Sex: M F

Address: _____ **City: _____ State: _____ Zip: _____**

Phone Number: _____ **Physician**: _____ **Email Address**:_____

Mother's Full Name: _____ Father's Full Name: _____

Payment Eligibility (circle if applicable):

(If you have circled one of these payment eligibility options, your child qualifies for VFC vaccine & no payment is required but donations accepted)

Medicaid/MCO Enrolled Company _____MCO #_____
No Insurance
American Indian/Alaskan Native
Underinsured (insurance that does not cover immunization)
(Children whose health insurance covers the cost of vaccination, even if the plan deductible is not met do not qualify. We are required by state to get a copy of your insurance card to verify. Please call our office at 515-961-1074 to verify before vaccination.)

OR
Wellmark BC/BS or United Health Care Insurance_____ Member ID#_____ Group #_____

Card holder name:_____Card Holder DOB_____ Relationship_____

OR
A donation of $24 is suggested

1) Is your child 8 years old or younger? Yes No If **NO, STOP** If YES, go to #2

2) Has your child received a total of 2 or more doses of seasonal flu vaccine before July 1, 2018?
(The 2 doses need not have been received during the same flu season.) Yes (1) No (2)

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 my child 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.

Parent/Guardian Signature: _____ Date: _____

For office use:
1st Dose: Site: RD LD RT LT Lot #_____ Manufactured by:_____

VFC Supply (circle one): Yes/No Date Given: _____ Administered by: _____RN

2nd Dose (if needed) Site: RD LD RT LT Lot #_____ Manufactured by:_____

VFC Supply (circle one): Yes/No Date Given: _____ Administered by: _____RN

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: _____

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)

immunization action coalition
IAC
immunize.org