Harrison County Health Department – 2015/2016 Seasonal Influenza Vaccine Vaccination Consent Form

Section 1: Information about Patient to Receive Vaccine (please print)

PATIENT'S NAME (Last)	(First)	(M.I.)	**PATIENT'S DATE OF BIRTH:**	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**PATIENT'S AGE:**	**PATIENT'S GENDER:** ☐ **FEMALE** ☐ **MALE**
PATIENT'S ADDRESS:			**DAYTIME PHONE NUMBER:**	
CITY:	**STATE:**	**ZIP:**		

Section 2: Screening for Vaccine Eligibility

Please Answer The Following Questions:	**YES**	**NO**
Would this be the patient's very first lifetime influenza vaccine?	☐	☐
Has the patient ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
Is the patient ill with fever today?	☐	☐
Does the patient have a serious allergy to eggs?	☐	☐
Has the patient ever had Guillain-Barré Syndrome?	☐	☐
Is the patient taking Coumadin or Theophylline medication, or an Aspirin Therapy regimen?	☐	☐
Does the patient have any allergies or serious medical condition[s] such as Heart Disease, Diabetes, Kidney Disease, Asthma or other Pulmonary Disease?	☐	☐
Is the patient pregnant? **YES** ☐ **NO** ☐ — If yes, does patient have a *Written Doctor's Order* for influenza vaccine? **N/A** ☐	☐	☐
Is the patient currently taking chemotherapy, steroid therapy, or in close contact with someone who is?	☐	☐
Does the patient have an active neurological disorder?	☐	☐
Does the patient have any other medical condition not disclosed on this form?	☐	☐

Section 3: Insurance Coverage ⇨ Please check "Yes" to the program you wish to use, "No" to all others

Insurance Provider:	**YES**	**NO**
Is the patient covered by Medicare or Medicaid?	☐	☐

Medicare:			**YES**	**NO**
Is the patent covered under Medicare?			☐	☐
If Yes, Beneficiary Name		Claim Number:		

Medicaid:			**YES**	**NO**
Is the patent covered under Medicaid?			☐	☐
If Yes, Beneficiary Name		Claim Number:		

If Medicaid, Please Indicate Provider:		
☐ Care Source	☐ Molina	☐ United Health Care
☐ Paramount	☐ Buckeye	☐ Ohio Med

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Section 4: Consent

By signing this form, I agree to the following:

I understand that there is always a possibility of an adverse reaction to any vaccine or drug. To the best of my knowledge I understand the benefits and risks of the seasonal influenza vaccine. I have had the opportunity to review the CDC Vaccine Information Sheet and do herby request to receive this vaccine for myself, my minor child, or person that I have legal guardianship over. I understand that no personal information about me will be released except for reporting purposes only to the Ohio Department of Health and the Centers for Disease Control and Prevention.

SIGNATURE: _____ DATE: _____

Public Health
Prevent. Promote. Protect.

~*~*~*~*~*~*~*~*~*~*~*~*~*~*~*~*~*~ **Staff Use ONLY Below This Line** ~*~*~*~*~*~*~*~*~*~*~*~*~*~*~*~*~*~*

Section 5: Vaccine Source

☐ State Supplied ☐ VFC Program ☐ HCHD Supplied ☐ Other: _____

Section 6: Vaccination Record

							|-----------Administration Site-----------|	
Vaccine Type	**Date Administered**	**VIS Given? Yes**	**No**	**VIS Date**	**Vaccine Manufacturer**	**Vaccine Lot Number**	**Left Deltoid**	**Right Deltoid**	**Other (Specify)**
Inactivated Seasonal Influenza Vaccine		☐	☐	07 August 2015	GlaxoSmithKline	Lot # 9Z429 Exp: 6/30/16	☐	☐	

Signature of Vaccine Administrator: _____