INFLUENZA VACCINE CONSENT FORM 2016-2017

Information *(Print all information)*

Name *First,* *Mi* *Last*

Parent/Guardian Name *(if Person is less than 18 years)* **Date of Birth** *(Month-Day-Year)* *AGE*

Street Address **City** **State** **Zip Code**

(_____)_____
Phone **SS#**_____

Sex: ☐ Male ☐ Female ☐ Other: _____

Race and Ethnicity: Please check **all that apply :**
☐ American Indian/Alaskan Native ☐ White ☐ Native Hawaiian/Pacific Islander
☐ Black or African American ☐ Asian ☐ Other:_____

Hispanic/Latino:
(check one below)
☐ Yes ☐ No

Screening Information *(Please check "yes" or "no" for each question)*

	Yes	No
Does the person to be vaccinated suffer from a sensitivity or allergy to egg, egg products, thimerosal or a component of the vaccine?	☐	☐
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐
Has the person to be vaccinated ever had Gullianin-Barre' syndrome?	☐	☐
Have you received the flu vaccine before?	☐	☐
Is the person receiving the vaccine pregnant? (answer only if female)******	☐	☐
Is the person to be vaccinated sick today?	☐	☐

Health Insurance Information

MEDICARE NUMBER_____

☐ **Private Insurance** (other than Medicaid):

Information from insurance card: Insurance Company: _____

Subscriber ID or member #:_____ Group #: _____

Name of person under whom patient is covered:_____ Birth date of insured : _____

Phone # on insurance card: _____ Payor/EDI# _____

Claims address on insurance card: _____

Medicaid Managed Care Plans *(check one below)**:*** Managed Care ID#:_____

☐ CareSource ☐ MOLINA HEALTHCARE ☐ PARAMOUNT ADVANTAGE ☐ UnitedHealthcare Community Plan

☐ **Ohio Medicaid:** Healthy Start Healthy Families **MEDICAID # *(12 digits)***: _____

TURN OVER PLEASE

Signature *(All forms must be signed)*

Consent for Use of Protected Health Information & Claims Assignment: I hereby consent to the use and disclosure of my personal health information for the purpose of health care operations, along with the assignment of all payment from the insurer listed above to KCHD with the service contemplated herein. Vaccine Authorization: My signature on this form indicates that I have requested that the vaccine indicated below be administered to me by KCHD. I relieve the KCHD and the administering Nurse and personnel of any liability for any reactions that should occur. In the case of occupational exposure, KCHD has patient permission for blood testing for patient and employee safety alike. I have read or have had explained to the information from the 2016-17 Vaccine Information Statement and understand the risks and benefits of the vaccine. I understand I will be responsible for the payment for the below vaccine, these services are not free, and that nonpayment by the insurance company or patient will result in collections for the amount due. If consenting for another: I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration.

PATIENT/GUARDIAN SIGNATURE:_____ **Date:**_____/_____/_____

Relationship to patient ☐ Mother ☐ Father ☐ Legal Guardian

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Health Dept. USE ONLY:

Vaccine lot number **9PX3H**	**Site of injection** ☐ **RD** ☐ **LD** ☐ **RT** ☐ **LT**
Vaccine Manufacturer ☐ **Sanofi Pasteur** ☐ **GSK**	**VACCINE DOSAGE** ☐ **0.25ml** ☐ **0.5ml**

VFC Private

Administered by:	Date:

eClinicalworks: ☐ VIS Date: **8/7/2015**