

Cleveland County Health Department Consent for Seasonal Flu Vaccine 9/26/09

PLEASE PRINT

Please complete if school staff or student

Please Check: <input type="checkbox"/> Staff <input type="checkbox"/> Student School name _____ Grade(if student) _____
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Triage staff to complete

Vaccine to be used: (circle)	
FluMist	Fluvirin
Flulaval	Fluzone

What type of medical insurance do you have? (Check all that apply & give card to clerk to copy)

Medicare Medicaid Private Insurance None (Self-Pay)

Are you pregnant? _____ Have you ever had a reaction to a Flu shot?

Last Name	First Name	Middle Initial	Birthdate	Age
Race	Sex	Social Security Number	Marital Status	
Address (Street number and name)			City	
State	ZIP	County	Phone Number	

Notice of Privacy Statement Given

I have read or have had explained to me the information in the appropriate

Influenza Vaccine Information Statement:

I have had a chance to ask questions and they were answered to my satisfaction.

I believe I understand the benefits and risks of receiving the above vaccine and ask that the vaccine be given to me or to the above named person for whom I am authorized to make this request. To the best of my knowledge, I am not allergic to the requested vaccine and do not have any other medical condition that would prevent me from receiving the vaccine.

Signature of the person to receive the vaccine or person authorized to make the request:

X _____ Date: _____

For Clinic / Office Use

<i>Influenza Vaccine</i>	
Allergies/ Contraindications: _____	VIS Date 8/11/2009
Date Administered: _____	Ldeltoid R deltoid Inhaler
Vaccine Manufacturer: _____	Lot # / Exp Date: _____
Signature of Vaccine Administrator: _____	Prov #: _____
State Supplied Vaccine Used: <input type="checkbox"/> Yes <input type="checkbox"/> No	

<i>Insurance/Medicare/Medicaid Information</i>	
Payor: _____	Medicaid# _____
Insured Name _____	Effective Date _____
Insured SS# _____	
Insured DOB _____	Medicare# _____
Policy No. _____	Group No. _____
	Effective Date _____

BRING COPY OF INSURANCE/MEDICAID/MEDICARE CARD

