RICHD ADULT FLU VACCINE CONSENT

FULL NAME: ____
First Name M Last Name

STATE EMPLOYEE ONLY
STATE EMPLOYEE ONLY: YES________NO______
LAST 4 OF SS#____________________

DATE OF BIRTH: ______________________ AGE: ________

CIRCLE GENDER: MALE FEMALE

STREET ADDRESS: ____ CITY: ________________________________

STATE: _________ ZIP CODE: _________________PHONE NUMBER:_____________________________

CIRCLE RACE: WHITE BLACK/AFRICAN-AMERICAN ASIAN AMERICAN INDIAN OTHER: ______________________

CIRCLE ETHNICITY: HISPANIC/LATINO NON-HISPANIC/LATINO

CIRCLE PREFERRED LANGUAGE: ENGLISH SPANISH OTHER

INSURANCE PRIMARY:________________________________ID#__________________________GROUP#_______________

SECONDARY:____ID#__________________________GROUP#_______________

**Do you have any allergies? (eggs, chicken, latex or medicines) Circle: YES NO
Have you ever had a **REACTION to a flu shot before: Circle: YES NO
**Do you currently have an active illness or are your taking antibiotics? Circle: YES NO
**Have you had Guillain-Barre Syndrome? Circle: YES NO
**Have you traveled outside of the US within the last 30 days? Circle: YES NO
**Have you been in contact with anyone who has traveled outside of US within the last 30 days? Circle: YES NO

If you answer "yes" to any of the above questions, please let the nurse know

JOINT NOTICE OF PRIVACY PRACTICES GIVEN

I HAVE READ OR HAD THE INFORMATION ABOUT THE INFLUENZA VACCINE EXPLAINED TO ME. I WAS GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I UNDERSTAND THE BENEFITS AND RISKS OF THE INFLUENZA VACCINE AND REQUEST THE VACCINE BE GIVEN TO ME OR THE PERSON FOR WHOM I AM AUTHORIZED TO MAKE THIS REQUEST. I UNDERSTAND THAT THE IMMUNES GIVEN TODAY WILL BE ENTERED INTO THE STATE DATA BASE, UNLESS I DECLINE. THE LAST FOUR DIGITS OF YOUR SOCIAL SECURITY NUMBER IS SO THAT YOUR BILL WHEN SUBMITTED CAN BE READILY IDENTIFIED AND PAID .

X ____

PRINTED NAMED

X ____ ____________________________

SIGNATURE of person receiving vaccine or parent/guardian **DATE**

AGENCY USE ONLY PP STOCK ONLY

FLU VACCINE 2022-2023

FLUBLOK:______

FLUZONE QUAD: ______

HIGH DOSE: ________

Office Use Only: **BILLING**
Clinic Site: ______________________________
Payment: _________ cash/check/cc#____________
Medicare _____ Private Insurance _____ IPA Adult____
Bill Township _____________________________
Bill County for Employee/dependent: _______
State Employee:_______

LOT#__________

EXP DATE:__________

VIS GIVEN:____
8/6/2021

SIGNATURE OF NURSE ADMINISTERING VACCINE:____