PUBLIC HEALTH SERVICES DISTRICT
COCONINO COUNTY

Seasonal Flu Consent Form 2016-2017

Patient Information

Last and First Name:	MI:	Mother's Maiden Name:
Address:	City, State, Zip code:	Phone #:

DOB (MM/DD/YY): / /	Age:	Male □	Female □	Transgender □	Pregnant □ # weeks:

Race/Ethnicity (circle all that apply):

African American	□	Asian	□	Native Hawaiian or Pacific Islander □
Native American	□	White	□	
Hispanic	□	Other	□	

Guardian and/or Emergency Contact Information:

Last and First Name:	Phone #:	Relationship to Patient:

Insurance (mark all that apply):

□ Uninsured □ Underinsured (insurance does not cover vaccines)

□ AHCCCS □ Native American/ Alaskan Native

□ **Insured** **Name of Primary Insurance:** Subscriber Name:

ID #	Group #	SS #	DOB

Name of Secondary Insurance: Subscriber Name:

ID #	Group #	SS #	DOB

Screening for the Injectible Influenza Vaccine

If the patient is a child, how many doses of flu vaccine has your child ever received before July 1, 2016?

□ 0 Doses □ 1 Dose □ 2 or more Doses

If the patient is a child, has your child received flu vaccine this flu season (since July 1, 2016)?

□ No □ Yes. If yes, Please tell us the number of doses and dates of vaccine(s): # Doses:

1st Dose, Date Received (MM/DD/YY): / / 2nd Dose, Date Received (MM/DD/YY): / /

Please check YES or NO for each question. If you answer 'YES' to one or more of the 5 questions, the patient may not be able to get the flu vaccine, unless there is a note from your healthcare provider saying it is okay for the patient to get the flu vaccine. If you answer 'NO' to all these questions, the patient will receive the vaccine. If you are not sure of the answers, check with your healthcare provider.

	No	**Yes**
1. Are you, the patient, sick today?	□	□
2. Does the patient have a problem eating eggs?	□	□
3. Does the patient have an allergy to gentamicin, neomycin, polymixin, or gelatin?	□	□
4. Has the patient ever had a serious reaction to a flu vaccine in the past?	□	□
5. Has the patient ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	□	□

I have read or received the Vaccine Information Statements (VIS), about the seasonal influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I agree to have Coconino County release my information about this vaccination to the Arizona State Immunization Information System (ASIIS) and other healthcare providers upon request. *(Please cross out this statement if you do not want this information entered into ASIIS.)* I understand the benefits and risks of the influenza vaccine and request to receive the vaccine today. When insurance is billed, I hereby authorize CCPHSD to furnish information to insurance carriers concerning my visit and I assign payments for medical services rendered to CCPHSD. **I understand that I am financially responsible for all charges whether or not covered by insurance.** I have received a copy of the Patient Rights and Responsibilites and the HIPAA Confidentiality Notice.

Patient/Guardian Signature Date

FOR EMPLOYEE USE ONLY

Clinic Location: □ King St □ Other: _____

Payment Details: Client may request copy for records. Please ensure all areas are completed for billing purposes

FEE: $30.00 / $21.00

□ Insurance □ Client □ Contract: _____

Receipt #:	Payment type:	Cash	Check	CC

Vaccination Details: VFC / VFA

Age Group/ Type	MGF	Lot#	Site	Route	Dose	Initials
6-35 months	Sanofi		LD / RD	IM	0.25 ml	
6 months + w/ Pres.	Sanofi		LD / RD	IM	0.25 ml 0.5 ml	
36 months + Pres. Free	Sanofi		LD / RD	IM	.5 ml	
Intradermal	Sanofi		LD / RD	ID	0.1 ml	
High Dose	Sanofi		LD / RD	IM	0.5 ml	

_____

Nurse's Signature Date administered & VIS Given (Date of VIS- 08/07/15)

Notes: