



POLK COUNTY HEALTH DEPARTMENT INFLUENZA CONSENT PC3

CLINIC SITE: _____ CLERK INITIALS: _____

SECTION A

FIRST: _____ LAST: _____ MI: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
PHONE: (____) _____ - _____ BIRTHDATE: ____/____/____ AGE: _____ GENDER: MALE FEMALE

SECTION B

- 1. Any long- term health problem- ex: heart, kidney, lung disease (asthma), diabetes, anemia?
2. Are you allergic to eggs or Thimerosal (mercury containing preservative used in vaccines)?
3. Ever had an allergic reaction/other problem after a vaccination(shortness of breath, hives, etc.)
4. Have you ever had Guillian Barre Syndrome?
5. Do you feel ill today or have an elevated temperature over 100.1 degrees?

SECTION C

COMPLETE ONLY IF WANTING FLU-MIST AGE 2-49

- 1. Any long- term health problem- ex: heart, kidney, lung disease (asthma), diabetes, anemia?
2. Weakened immune system because of HIV/ Aides or other disorders or treatments like steroids or cancer treatments?
3. Live with/have close contact with anyone- severely weakened immune system requiring care in a protective environment?
4. Under 17 yrs old and take salicylates (aspirin)?
5. Received any live vaccine (Chickenpox, MMR, Shingles, Yellow Fever) in past 4 weeks?
6. Are you pregnant or could become pregnant within the next month?

SECTION D

HEALTH INSURANCE INFORMATION

Do you have health insurance YES NO

If YES-Please list name of insurance plan: _____ (WE DO NOT ACCEPT COVENTRY INSURANCE)

We will file your claim with the insurance plans that we participate in. If you have a co- pay, you will be billed at a later date. Please have card ready to scan. If uninsured & 19 years and older, a \$20 fee applies. Unable to pay the full amount? Any amount is appreciated!

AMOUNT PAID: _____

SECTION E

18 YEARS & UNDER

- Are you Underinsured? (Plan does NOT cover vaccinations)
Are you Native American/Alaskan Native?
Are you uninsured? (No insurance)
Answer "YES" to any of the above, a \$19 administration fee applies. Unable to pay full amount? Any amount is appreciated!
Are you 6 months to 18 years old with Medicaid?
We will bill your Medicaid insurance for the admin fee.

I acknowledge receipt of the "Notice of Health Information Privacy Practices" for Polk County Health Department and understand all information is confidential/can only be released with my consent. I have received and have had the opportunity to read the information sheet for the flu vaccination and have opportunity to ask questions. I understand the benefits and risks of the vaccination. I authorize the healthcare providers of the Polk County Health Dept. I understand if insurance does not cover the services that I will receive a bill for those services.

SIGNATURE : _____ DATE: _____



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***** FORSTAFF ONLY *****

INFLUENZA- VIS DATE: 08/07/2015

Injectable Administration (3+ yrs): 90471 V04.81

Nasal Administration: 90473 V04.81

6-35 months (0.25ml) Quadrivalent 90687

Fluzone (0.5ml) Quadrivalent 90688

6-35 months Prefilled Quadrivalent 90685
Only available in VFC

Fluzone *High Dose* 90662
Preferred for 65+

FluMist 90672
Healthy 2-49y

DOSAGE: .25 ML IM .50 ML IM SITE: RD LD RT LT Bilateral Nares

MANUFACTURER: _____

LOT #: _____

Expiration Date: _____

STAFF SIGNATURE: _____

OFFICE USE ONLY

ZIP _____

TRACKING _____

IRIS _____