



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? YES NO
- 2. Are you allergic to eggs or Thimerosal (mercury containing preservative used in vaccines)? YES NO
- 3. Ever had an allergic reaction/other problem after vaccination (shortness of breath, hives, etc.) YES NO
- 4. Have you ever had Guillian Barre Syndrome? YES NO
- 5. Do you feel ill today or have an elevated temperature over 100.1 degrees? YES NO

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) YES NO

Are you Native American/Alaskan Native? YES NO

Are you uninsured? (No insurance) YES NO

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? YES NO

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: _____



POLK COUNTY HEALTH DEPARTMENT INFLUENZA CONSENT

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***** FOR STAFF ONLY *****

INFLUENZA- VIS DATE: 08/07/2015

Injectable Administration (3+ yrs): 90471 Z23

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+

DOSAGE: .25 ML IM .50 ML IM

SITE: RD LD RT LT

MANUFACTURER: _____

LOT #: _____

Expiration Date: _____

STAFF SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

TRACKING _____

IRIS _____