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 C 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 **$25** fee applies. If uninsured & choose high dose (65+), a $**50** fee applies. Unable to pay the full amount? Any amount is appreciated!*

AMOUNT PAID: _____

SECTION D 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:** _____

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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

□ 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***_____