Coffey County Health Department
Influenza Consent Form

Last Name ____________________ First Name ____________________ MI ______

Street Address/ PO Box ____

City ____________________ State ____________ County ________ Zip ______________

Male _____ Female _____ Date of Birth ________________ Phone# ________________

Age __________ Personal Physician ____________________

Please answer the following questions and information below

Have you ever had a flu shot before?---yes ____ no ____
Do you have a cold, fever, or acute illness?---yes ____ no ____
Are you allergic to chicken eggs or egg products?------------------------------------yes ____ no ____
Have you ever had an allergic reaction to flu vaccine or Pneumococcal vaccine?— yes ____ no ____
Have you been diagnosed with Guillain-Barre Syndrome?----------------------------yes ____ no ____
If you are 65 or older would you like the High Dose vaccine?———————————yes ____ no ____

I hereby certify that the foregoing history is true and complete to the best of my knowledge and request and authorize receipt of the influenza vaccine. I verify that I have been offered a copy of the Vaccine Information Statement. I hereby authorize CCHD to release any information necessary to file a claim for payment to my insurance company. I acknowledge that I have reviewed a copy of CCHD's Notice of Privacy Practices with the effective date of April 14, 2003. I have been offered a copy of the Vaccine Information Statement. I have read, had explained to me and understand the information in the vis. I consent to inclusions of the immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below. VIS Date 08/2015

Patient Signature ______________________________________ Date ______________

****

Cardholder Name ______________________________ ID# ______________________________
(*Exactly as it appears on card*)

Payment Method:

Cash/Check BCBS Medicare KanCare Other ______________________________

Pre-Filled 6-35 months Sanofi-Pasteur	Route LVL RVL	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications
Pre– Filled 36-Older Sanofi Pasteur	Route LD RD LVL RVL	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications
MDV (Multi Dose Vial) Sanofi Pasteur	Route LD RD	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications
FluBlok 50-64 yrs Sanofi Pasteur	Route LD RD	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications
High Dose 65– Older Sanofi Pasteur	Route LD RD	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications
PCV13 (VIS 11/05/15) PPSV23(VIS04/24/2015	Route LD RD	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications