**LOUP BASIN PUBLIC HEALTH DEPARMENT INFLUENZA CONSENT**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLIENT INFORMATION** | | | | | | | | | | | | | | | | | |
| LAST NAME | | | FIRST NAME | | | | | | MI | | MAIDEN NAME (IF APPLICABLE) | | | | | | |
| DATE OF BIRTH | AGE | SEX  M F | MOTHER’S MAIDEN NAME (FIRST AND LAST) | | | | | | | | PHONE  ( ) | | | | | | |
| YOUR STREET ADDRESS | | | | PO BOX \_\_\_\_\_ (IF APPLICABLE) | | | CITY | | | | | STATE | | | | ZIP | |
| EMAIL ADDRESS (FOR ACCESS TO PATIENT PORTAL, APPT REMINDERS, ETC.) | | | | | | | | | | | | | | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | | | | | | | | | |
| RELATIONSHIP OF CLIENT TO SUBSCRIBER □ SELF □ SPOUSE □ CHILD □ OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |
| SUBSCRIBER NAME (IF DIFFERENT THAN ABOVE) | | | | | SUBSCRIBER DATE OF BIRTH  (REQUIRED) | | | SOCIAL SECURITY # | | | | | | INSURANCE PROVIDER   * MEDICA * BLUE CROSS BLUE SHIELD   (MUST HAVE PHOTO/COPY OF CARD)   * MEDICAID *UHC NTC WELLCARE* * MEDICARE (SS# REQUIRED) * OTHER: | | | |
| STREET ADDRESS (IF DIFFERENT THAN ABOVE) | | | | | CITY | STATE | | | | ZIP | | | |
| PHOTO OF CARD (FRONT & BACK)  □ DRCHRONO □ PHOTO COPY ATTACHED □ STAFF DEVICE (DEVICE # ) | | | | | | | | | | | | | |
| **SCREENING QUESTIONNAIRE** | | | | | | | | | | | | | | | | | |
| **THE QUESTIONS BELOW MUST BE ANSWERED PRIOR TO RECEIVING ANY VACCINATION.** | | | | | | | | | | | | | **YES** | | **NO** | | **DON’T KNOW** |
| ARE YOU RUNNING A FEVER TODAY? | | | | | | | | | | | | |  | |  | |  |
| DO YOU HAVE ALLERGIES TO EGGS OR A VACCINE COMPONENT? | | | | | | | | | | | | |  | |  | |  |
| HAVE YOU EVER HAD DIFFICULTY BREATHING AFTER RECEIVING A VACCINATION? | | | | | | | | | | | | |  | |  | |  |
| HAVE YOU HAD A SEIZURE, BRAIN/NERVOUS SYSTEM DISORDER OR GUILLAIN‐BARRE? | | | | | | | | | | | | |  | |  | |  |

**I GIVE CONSENT** to the **Loup Basin Public Health Department** and its staff to vaccinate the person listed on this form. I have read or had explained to me the Vaccine Information Statement and understand the risks and benefits. I hereby grant permission to Loup Basin Public Health Department to release any pertinent information to the above insurance company upon request and any physicians to whom I might be referred.

Authorized Signature (client, if 19 or older, or parent/legal guardian) Today’s Date (month/day/year

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **VACCINE** | **FORM** | **AGE** | **MAN/LOT/EXP** | **SITE** | **NURSE/DATE** |
| Sanofi | FluBlok | 18+ |  | LA RA |  |
| Fluzone PREFILLED | 6 mo+ |  | LA RA |  |
| High-Dose | 65+ |  | LA RA |  |
| GSK | FluLaval PFS | 6 mo+ |  | LA RA |  |
| MD Vial | 6 mo+ |  | LA RA |  |
| Fluarix / Flucelvax PFS | 19+ **AIP** |  | LA RA |  |

DrChrono /

NESIIS /

(INACTIVATE)

Roster /

Billed /

Paid Cash/Donation

A picture containing timeline

Description automatically generated