**LOUP BASIN PUBLIC HEALTH DEPARMENT INFLUENZA CONSENT**

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| **CLIENT INFORMATION** |
| LAST NAME | FIRST NAME | MI | MAIDEN NAME (IF APPLICABLE) |
| DATE OF BIRTH | AGE | SEXM 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 |  |
| FluzonePREFILLED | 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

