

## VACCINATION CONSENT FORM

I have been given a copy of the August 7, 2015 "Vaccine Information Statement" for influenza vaccine and the Nemaha County Community Health Services' Notice of Privacy Practices. I have read, or have had explained to me, the information in the "Vaccine Information Statement." My questions have been answered satisfactorily, and I ask that the seasonal influenza vaccine be given to me or to the person named below for whom I am authorized to make this request. You may release this information to my doctor. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below.

Name of Person to be vaccinated \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

Gender (check one):                  Ethnicity: Hispanic or Latino (check one)    Doctor: \_\_\_\_\_

Male     Female                   Yes     No

Race (check one):  American Indian/Alaskan Native     Asian     Black/African American     White     Other

Check if you have one of these accepted forms of payment (copy of both sides of insurance card must be attached):

Medicare     KanCare (Amerigroup, United Healthcare Plan K, Sunflower)     BCBS     Century Health

Meritain     Cigna     United Healthcare     Coventry     First Health Network     Aetna     CoreSource

Check answer below:

1. Do you have health insurance?     Yes     No

2. Does your insurance cover immunizations?     Yes     No

3. Does your insurance cap vaccine costs at a certain limit?     Yes     No

For insurance policies that do not cover immunizations or cap vaccine costs, documentation from your insurance company is required and must be attached to this form to be eligible for the Vaccines For Children (VFC) Program.

### Immunization Screening Questionnaire

1. Is the person to be vaccinated sick today or experiencing high fever?                   Yes     No

2. Has the person to be vaccinated ever had Guillain-Barre' Syndrome?                   Yes     No  
(A syndrome in which the body damages its own nerve cells resulting in weakness and sometimes paralysis)

3. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?  
 Yes     No

4. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?  
 Yes     No

5. If the person receiving a flu shot is **under 9 years of age**, did this child receive 2 or more total doses of influenza vaccine **before** July 1, 2018?     Yes     No     Don't Know

I agree to pay any remaining amount of my bill to Nemaha County Community Health Services that my insurance company does not pay.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

## PROVIDER INFORMATION

Vaccine Provider: Nemaha County Community Health Services			Clinic Site:		
Street Address: 1004 Main Street	State KS	Zip Code 66534	Street Address:	State	Zip Code

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the manufacturer, lot #, and expiration date)

## FOR CLINICAL USE ONLY

Vaccine	Dose	Ext.	Site	Route	VIS Date	Mfr./Lot #	Exp. Date
<b>Private Inventory Influenza</b>	1 2	RT  LT	Deltoid Vastus Lat	IM 0.25ml 0.50ml	08/07/15	Sanofi Pasteur UI985AC (High Dose) QFAA1806 (Flublok) UT6259JA (0.25mL PFS) UI996AA (05. mL PFS) UI998AD (MDV) UJ029AB (High Dose) UJ008AC (0.5 mL PFS) UJ005AE (MDV)	3/22/19 6/5/19 6/30/19 5/2/19
	1 2	RT  LT	Deltoid Vastus Lat	IM 0.25ml 0.50ml	08/07/15	Sanofi Pasteur UT6262MA (0.25mL PFS) UT6258JA (0.5mL PFS)	6/30/19

\_\_\_\_\_  
Signature and Title of Vaccine Administrator

\_\_\_\_\_  
Date