Influenza Vaccine Consent Form

Information collected on this form will be used to document authorization for receipt of vaccine(s)

Today's Date (mm/dd/yyyy):			Patient Social Security Number:
Patient's Name (Last, First, Middle Initial)			If Child/Minor Parents Signature:
Date of Birth (mm/dd/yyyy)	Gender ☐Male ☐Female		Ethnicity (Check One) ☐Hispanic ☐Non-Hispanic
Race (Check all that apply) ☐Asian ☐Black or African-American ☐American Indian or Alaska Native ☐Native Hawaiian or Other Pacific Islander ☐White ☐Other Race ☐Unknown			Mother's Maiden Name (Last, First, Middle Initial)
Eligibility Status ***PLEASE ATTACH CARD*** ☐American Indian / Alaska Native ☐Underinsured ☐Medicare ☐Medicaid ☐NC Health Choice ☐Other Insurance_____ ☐Not Insured ☐Blue Cross Blue Shield Subscriber Number:			
Mailing Address – ***Must Be Completed***		P.O. Box	
City	County	State	Zip Code
Home Telephone Number		Work Telephone Number	

The following questions will help us to know if you/your child can get the influenza vaccine. Please mark YES or NO for each question.

	YES	NO
1. Do you/your child have a serious allergy to eggs?	☐	☐
2. Do you/your child have any other serious allergies? Please list:	☐	☐
3. Have you/ your child ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Have you/your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐

I am authorized by the parent, guardian, or person standing in loco parentis of the above-named child to obtain needed immunizations for the child.

I/parental designee have received the "Vaccine Information Statements" (VIS) about the disease(s) and vaccine(s). I have had a chance to review the VIS(s) and to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request the vaccine(s) indicated below to be given to me or the person named above for whom I am authorized to make this request.

I have been provided access to the Foothills Health District Notice of Privacy Practices. I agree for Medicare, Medicaid and/or Insurance, if applicable, to be billed and I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the Foothills Health District.

SIGNATURE – Person to receive vaccine or person authorized to sign on the patient's behalf **X**	Date:

FOR OFFICE USE

Vaccine	Lot #	VIS Pub. Date	Nurse Signature	Vaccine Code	Body Site
Afluria 6-36 months		08/06/2021		90687	RV LV RD LD
Afluria 36 months and up		08/06/2021		90688	RV LV RD LD
Fluzone 6 months and up		08/06/2021		90688	RV LV RD LD
Fluzone High Dose		08/06/2021		90662	RV LV RD LD
Flulaval 6 months and up		08/06/2021		90688	RV LV RD LD
Other		08/06/2021			RV LV RD LD

Dx Code: Z23

Injection Fee:
☐ 90471
☐ G0008 – Medicare Only

Vaccine Supply:
☐ Private
☐ State

NCIR Data Entry by _____ Name _____ Date

☐R ☐M
Select County

Insurance Billed by _____ Initial