Influenza Vaccine Consent Form

2023

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 8/6/2021) 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 #	Expiration Date	Nurse Signature	Vaccine Code	Body Site
Afluria				90686	RV LV RD LD
Flulaval (State)				90686	RV LV RD LD
Fluzone High Dose				90662	RV LV RD LD
Fluarix				90686	RV LV RD LD
					RV LV RD LD
					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