Influenza Vaccine Consent Form-FLU SHOT please complete sections 1-4, sign & date

VFC VFCA PRIV elig code:_____

Section 1: Information about Patient to Receive Vaccine

PATIENT NAME (Last)	(First)	(M.I.)	**PATIENT DATE OF BIRTH** **month**_____ **day**_____ **year** _____	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**PATIENT AGE**	**SEX ASSIGNED AT BIRTH** ☐ **M** ☐ **F**
MAILING ADDRESS			**SSN:**_____ **PHONE:**_____ **EMAIL:**_____	
CITY	**STATE**	**ZIP**		
RACE: _____	**ETHNICITY:** _____		**PHYSICIAN:** _____	

Section 2: Screening for Vaccine Eligibility

Please read carefully and mark YES or NO for each question. The nurse will discuss any yes responses with you.

DOES THE PERSON RECEIVING THE FLU SHOT….	YES	NO
1. Have any allergies? Please list:_____	☐	☐
2. Have a serious allergy to eggs? Please describe your reaction: _____	☐	☐
3. Ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness)?	☐	☐

Section 3: Payment Information

☐ Insurance ☐ None/Self Pay ☐ Employer is paying/Name of Employer/Dept_____

Name of Insurance:_____ ID#:_____Group#:_____

Primary Insured's Name:_____DOB:_____Relation to Patient:_____

Address:_____City:_____St:_____Zip:_____

Section 4: Consent For Vaccination:

☐ I have read or had explained to me the information contained in the Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

☐ I have received or reviewed the Notice of Privacy, which provides a description of information uses and disclosures.

☐ I consent to the shared use of demographic information and authorize this vaccine to be recorded into the State of Montana Immunization Registry for immunization health purposes and that it may be released to health care providers, childcare providers and schools across the state that may provide continuing immunization services. I understand I can revoke this authorization and have the record removed at at any time by contacting my local county health department.

☐ I authorize payment of medical benefits to this county health department for services rendered. I understand that the patient or parent/guardian is responsible for any unpaid balances. I understand that any unpaid balance may be sent to a collections agency.

Signature of Patient or Parent/Legal Guardian _____ Date:_____

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Route	Date Dose Administered	Lot Number	Name and Title of Vaccine Administrator
Influenza	☐ LDIM ☐ RDIM	/ /		