FLU VACCINE CONSENT FORM

For Staff Use Only:
☐ VFC ☐ PRI Code:_____

Name:_____
First, Last, MI

Date of Birth:_____ Age:_____ Gender at Birth: ☐ Male ☐ Female

Social Security # _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Email:_____

RACE: ☐ White ☐ American Indian ☐ Hispanic ☐ Other Physician:_____

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:_____

Health Questions

✱Do you have allergies? If yes, please list:	☐ Yes	☐ No
✱ Do you have allergies to eggs? If yes, describe your reaction:	☐ Yes	☐ No
✱Have you ever been diagnosed with Guillain-Barre' Syndrome	☐ Yes	☐ No
✱Do you have long-term health problems with? ☐ Heart disease ☐ Kidney disease ☐ Metabolic disease, such as diabetes ☐ Lung disease ☐ Asthma ☐ Anemia ☐ Other blood disorders	☐ Yes	☐ No

Acknowledgements and Consent

All patients or parents/guardians please check each box and sign and date the signature box below.

☐ I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction.

☐ I understand the benefits and risks of the vaccine(s) and request the vaccine(s) to the person named above for whom I am authorized to make this request.

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

☐ I consent to the shared use of demographic information and authorize my immunization records 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 that I can revoke this authorization and have my record removed 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:_____ Date:_____

Clinic Date: _____ **Nurse Signature:** _____

Vaccine	Lot Number	Site
Flu		LDIM RDIM