

Consent for Vaccination -Please complete this form down through the signature/date line.

Information about the person to receive the vaccine - please print clearly		
Last name	First Name	Middle Initial
Mailing Address	Phone Number	
City/State	Zip Code	
Birth date	Age	
If under 19 yrs, please list parents full names:		

PLEASE ANSWER the questions below for the person receiving the vaccine today: Circle Yes or No

- Are you ill or do you have a fever today? ----- Yes No
- Have you had a serious reaction to a previous flu vaccine? ----- Yes No
- Do you have a history of Gullain-Barre Syndrome within 6 wks of a previous flu shot? -----Yes No
- Do you know or suspect that you are pregnant? ----- Yes No
- Do you have asthma, or a recent episode of wheezing (1yr) or recurrent episodes of wheezing? -----Yes No
- Do you have a weakened immune system, received immune globulin, or on long-term aspirin treatment? -----Yes No
- Do you have an allergy to eggs, thimerisol, mercury or latex? -----Yes No
- Do you have any long-term health problems? (heart, kidney, metabolic)-----Yes No
- If you are age 65 yrs or older, have you ever had a pneumonia shot? -----Yes No If yes, at what age_____

CHECK one box to indicate how you plan to pay for this service:

I have Medicare Part B coverage: Medicare Claim Identifier # & letter:

Note: If you have only Medicare Part A we cannot bill your insurance. Wellmark Advantage Plan thru Blue Cross is the only HMO we can bill. For any other HMO, you may either contact your physician or your HMO for a flu shot, or you may pay for your flu shot today

I have verified that my health insurance covers flu vaccine. A copy of my health insurance card is attached.
Note: **You will receive a bill for the cost or the co-pay if insurance does not pay.**

I have current Title 19/Medicaid coverage. Note: adults age 19 years and older must receive their flu vaccine at the physician office. Please take this form to the office during their flu clinic times.

Title 19 Medicaid # & letter:

- I have no insurance or my insurance does not cover immunizations. Children Ages 6 mo - 18 years can receive vaccine through the VFC (Vaccine For Children) Program. Administrative fee of \$14 is requested.
- Self pay. I will pay \$27 for a flu shot or \$45 for a Flu Mist

CONSENT AND SIGNATURE: I have read the vaccine information statements or have had them explained to me. I have had the chance to ask questions and these have been answered to my satisfaction. I understand the benefits and the risks of the vaccine and consent to receive it. I accept responsibility for seeking medical attention for any problems with the vaccination. I understand that this vaccine may cause flu-like symptoms in some people and in rare incidents Guillain-Barre Syndrome. I am consenting to flu shot, flu mist, or pneumonia vaccine as appropriate for me. I authorize billing of this vaccination to my health insurance and if my health insurance does not pay, I will accept full financial cost for the vaccination.

SIGNATURE: _____ **Date** _____

-----FOR NURSES ONLY: Vaccine Administration Record-----

<u>INFLUENZA VACCINE</u>	Dose/Site	0.2ml intranasal	0.25 ml IM	0.5 ml IM
Mfg/Lot#		RA	LA	RL LL
	Date _____	Administered by: _____		
Does child under 9 yrs need to return for dose # 2? Yes / No If yes, educate and give return date slip.				

<u>PNEUMONIA VACCINE</u> (65 Yrs and older, 1 st Dose only)	Dose/Site	0.5 ml IM	RA	LA
Mfg/Lot#				
	Date _____	Administered by: _____		