VACCINATION CONSENT FORM

I have been given a copy of the August 15, 2019 "**Vaccine Information Statement**" for influenza vaccine and the **Nemaha County Community Health Services' Notice of Privacy Practices**. I have read, or have had explained to me, the information in the "Vaccine Information Statement." My questions have been answered satisfactorily, and I ask that the seasonal influenza vaccine be given to me or to the person named below for whom I am authorized to make this request. You may release this information to my doctor. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below.

Name of Person to be vaccinated _____

Address _____ **City** _____ **State** _____ **Zip** _____

Date of Birth _____ **Age** _____ **Phone Number (__)** _____

Gender (check one): ***Ethnicity: Hispanic or Latino (check one)*** **Doctor:**_____

□ Male □ Female □ Yes □ No

Race (check one): □ American Indian/Alaskan Native □ Asian □ Black/African American □ White □ Other

Check if you have one of these accepted forms of payment ***(copy of both sides of insurance card must be attached)*:**

□ Medicare □ KanCare (Aetna, United Healthcare, Sunflower) □ BCBS □ Century Health □ GPHA

□ Meritain □ Cigna □ United Healthcare □ Coventry □ First Health Network □ Aetna □ CoreSource

Check answer below:

1. Do you have health insurance? □ Yes □ No
2. Does your insurance cover immunizations? □ Yes □ No
3. Does your insurance cap vaccine costs at a certain limit? □ Yes □ No

For insurance policies that do not cover immunizations or cap vaccine costs, documentation from your insurance company is required and must be attached to this form to be eligible for the Vaccines For Children (VFC) Program.

Immunization Screening Questionnaire

1. Is the person to be vaccinated sick today? □ Yes □ No
2. Has the person to be vaccinated ever had Guillain-Barre' Syndrome? □ Yes □ No
   (A syndrome in which the body damages its own nerve cells resulting in weakness and sometimes paralysis)
3. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine? □ Yes □ No
4. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? □ Yes □ No
5. If the person receiving a flu shot is **under 9 years of age**, did this child receive 2 or more total doses of influenza vaccine **before** July 1, 2020? □ Yes □ No □ Don't Know

I agree to pay any remaining amount of my bill to Nemaha County Community Health Services that my insurance company does not pay.

_____ _____

Signature of Patient or Parent/Guardian Date

PROVIDER INFORMATION

Vaccine Provider: Nemaha County Community Health Services			Clinic Site:		
Street Address: 1004 Main Street	State KS	Zip Code 66534	Street Address:	State	Zip Code

(Circle the appropriate vaccine, dose, extremity, site, route, and enter the manufacturer, lot #, and expiration date)

FOR CLINICAL USE ONLY

Vaccine	Dose	Ext.	Site	Route	VIS Date	Mfr./Lot #	Exp. Date
Private Inventory Influenza	**1 2**	**RT** **LT**	Deltoid Vastus Lat	IM 0.5ml 0.7ml	08/15/19	**Seqirus** P100247215 **Sanofi** QFAA2008 (Flublok) QFAA2014 (Flublok) UJ450AB (0.7mL High Dose) UJ461AB (0.7mL High Dose) UJ452AB (MDV) UT7005JA (0.5mL PFS) UT7006NA (0.5mL PFS)	6/30/21 5/24/21
Public Inventory Influenza	**1 2**	**RT** **LT**	Deltoid Vastus Lat	IM 0.5ml	08/15/19		

Signature and Title of Vaccine Administrator _____ **Date**