Pratt County Health Department

Public Private

2019-2020

Flu Consent Form

PATIENT INFORMATION:

First Name : _____ Last Name: _____

Previous Maiden or Other Last Name: _____

Address: _____ Phone: _____

City: _____ State:_____ Zip:_____ Sex: (circle)

Date of Birth: _____ Age:_____ Race:_____ Male Female

INSURANCE INFORMATION: ***If you have an insurance card we can copy, skip down to Questionnaire**

Please select type of insurance coverage.

☐ No Insurance

☐ Medicare Number: _____ **OR** Last 4 digits of SS# _____

☐ Insurance Company Name: _____ Social Security Number _____

Policy Holders Name: _____ Policy Holders Date of Birth: _____

Insured ID # : _____ Group # : _____ Relationship to Patient: Self / Spouse / Child

---

QUESTIONNAIRE: **Please answer the following questions by circling Yes or No:**

1. Have you ever had a flu shot before?	**Yes**	**No**
2. Are you sick or do you have a high fever today? (If yes, you should not receive vaccine until fever free for 24hrs.)	**Yes**	**No**
3. Have you been sick in past two weeks?	**Yes**	**No**
4. Are you allergic to chicken, eggs, or egg products?	**Yes**	**No**
5. Have you ever had an allergic reaction to the flu shot?	**Yes**	**No**
6. Are you pregnant, or think you may be?	**Yes**	**No**
7. Do you have an history of Guillain-Barre Syndrome (a paralyzing illness)?	**Yes**	**No**
8. Do you take cortisone, prednisone, other steroids, anticancer drugs or have had radiation treatments?	**Yes**	**No**
*** If you are over 18 years Old:** Are you current on your Tdap (Tetnus)	**Yes**	**No**
***If you are over 50 Years Old:** Are you interested in receiving the Shingrix (Shingles) Vaccine?	**Yes**	**No**
***If you are over 65 Years Old:** Are you interested in receiving the Pneumonia Vaccine?	**Yes**	**No**

Consent and Release Statement

I have been offered a copy of the Vaccine Information Statement (VIS) for the immunizations I am receiving. I herby authorize my insurance benefits to be paid directly to the clinic and acknowledge that I am financially responsible for any unpaid balance. I consent to the inclusion of this immunization data in the Kansas Immunization Registry for myself and on behalf of the person named above.

_____ _____

Patient or Guardian Signature **Date**

Please complete the front page only and return to the receptionist.

FOR OFFICE USE ONLY			
VACCINE	**Private Lot #**	**Public Lot #**	**Site**
			LD
6 MONTHS & UP Fluaval Flularix Fluzone	Private	Public	**RD**
Flublok 50 - 64 yrs. 18-50 yrs with Medical Conditions	Private	N/A	**RVL**
Fluzone Hi-Dose 65 yrs +	Private	N/A	**LVL**
Signature & Title of Vaccine Administrator		Date Given	Influenza VIS 08/07/2015 ☐

Pratt County Health Department
712 S. Main St.
Pratt, KS 67124
Ph: (620) 672-4135 Fax: (620) 672-1129