INFLUENZA VACCINATION CONSENT FORM

I have been offered a copy of the August 6, 2021 "**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. ALL INFORMATION IS CONFIDENTIAL I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below.

First & Last NAME of the person receiving the vaccination: **Date of Birth:** / / **Age:**

If recently change, previous Maiden or Other Name

Mailing Address: **City:** **State:** **Zip:**

If client is a MINOR, name of parent or guardian: **Phone Number:**

Sex: **Primary Care Physician:**

☐ **Male** ☐ **Female**

***PRIMARY INSURANCE INFORMATION*: Please provide the information:**

1. Do you have health insurance? ☐ Yes ☐ No

2. Does your insurance cover immunizations? ☐ Yes ☐ No

Please print the NAME/Policy Holder exactly as it appears on the insurance card: **Name of Insurance Company:**

KanCare: **Insurance member policy number #** **Group #**

☐ **Sunflower** ☐ **Aetna** ☐ **United**

Insurance Company Address, City, State and Zip Code

Immunization Screening Questionnaire

1. Is the person to be vaccinated currently sick or experiencing high fever? ☐ Yes ☐ No
2. Does the person to be vaccinated have a history of 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 any serious allergies? ☐ Yes ☐ No
   Please List_____
4. If the person receiving a flu shot is under 9 years of age, did he/she have the flu shot in the past? ☐ Yes ☐ No ☐ NA
5. Has the person to be vaccinated ever had a serious reaction to a previous dose of the flu vaccine? ☐ Yes ☐ No

By signing below I agree, Nemaha County Community Health Services, Inc. ***can bill my Insurance for any services rendered as applicable.*** **I understand I** ***will be responsible for any services provided which my Insurance does not cover.*** **I certify that the above information is correct to the best of my knowledge**.

X_____ **X**_____

Signature of Patient or Parent/Guardian Date

PROVIDER INFORMATION (clinical use only)					
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	08/06/2021	**Sanofi** UT8079AA (HD) UT8094CA (HD) UT8150CA (HD) UT8076KA (Pfree) UT8109KA (Pfree) UT8129MA (Pfree) UT8219KA (Pfree) U8097AA (MDV)	6/30/24
Public Inventory Influenza	**1 2**	**RT** **LT**	Deltoid Vastus Lat	IM 0.5ml	08/06/2021	**Sanofi** U8070AA (Pfree) **GlaxoSmithKline** 2MA3K (Pfree)	6/30/24

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