HOWELL COUNTY HEALTH DEPARTMENT
2023-2024 INJECTABLE INFLUENZA CONSENT FORM

For office use only:
VFC Eligible: Yes _____ No _____
Is Booster dose needed? Yes _____ No _____

PLEASE PRINT AND COMPLETE ALL INFORMATION

PATIENT FIRST NAME:	MI:	PATIENT LAST NAME:	DATE OF BIRTH:	AGE:

STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

PHONE NUMBER:	GENDER:
	☐ MALE ☐ FEMALE (IF FEMALE, ARE YOU PREGNANT? ☐ YES ☐ NO)

DO YOU HAVE INSURANCE OTHER THAN MEDICAID? ☐ **YES** ☐ **NO**

IF YES, NAME OF INSURANCE _____ **POLICY #**_____

DO YOU HAVE MEDICAID? ☐ **YES** ☐ **NO DCN#**_____ **M/C CARRIER**_____

DO YOU HAVE MEDICARE? ☐ **YES** ☐ **NO IF YES, WHICH COVERAGE DO YOU HAVE: PART A OR PART B**

The following questions will help us determine if there is any reason we should not give you (or your child) inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain:

	YES	NO
1. Is the person to be vaccinated sick today?	☐	☐
2. Does the person to be vaccinated have an allergy to latex, mercury, thimerosal, gelatin, chicken eggs/feathers, or other vaccine components?	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐
4. Has the person to be vaccinated ever had Guillian-Barre syndrome or any other neurological diseases?	☐	☐

AUTHORIZATION AND CONSENT:

The following lists various ways in which we may use or disclose your health information for purposes of treatment, payment, and health care operations.

For Treatment: We may use and disclose your health information in providing you with treatment and services and coordinating your care and we may disclose information to other providers involved in your care. Your health information may be used by doctors, nurse practitioners and nurses, as well as by hospital services, pharmacists, laboratories, and other persons involved in your care. Your health information may be shared with state and federal agencies as required by state and federal laws and/or rules which require reporting of individually identifiable protected health information (PHI). These laws also detail what data are confidential, under what circumstances the data may be disclosed, and penalties for inappropriate disclosures.

For Payment: We may use and disclose your health information for billing and payment purposes. We may disclose your health information to insurance or managed care company, Medicare, Medicaid or another third party payer. We may also disclose your information so that other covered entities may obtain payment for treatment that they have provided.

For Health Care Operations : We may use and disclose your health information as necessary for health care operations, such as management, personnel evaluation, education and training, and to monitor our quality of care. We may disclose your health information to another entity with which you have or have had a relationship if that entity requests your information. This information will only be shared with other health care providers who have signed an agreement with our agency.

"I have read or have had explained to me the information on the form about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request."

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

---------- **FOR OFFICE USE ONLY** ----------

Influenza QIV VIS (08/06/2021)

☐ **Prefilled Syringe 0.5 mL (6 mths & older)** ☐ **Pediatric PFS 0.25 mL (6-35 mths)** ☐ **Multi-Dose Vial 5 mL (36 mths & older)**	**Lot #:** **Manufacturer Name:** **S. Pasteur GSK Seqirus**	**Site: ____LD ____ RD ____ LL ____ RL Other _____** **Delivery Site: _____ IM**
Administrator Signature	**Date** _____ / _____ / _____	**VAXCARE VFC 317 AP**

"AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER"
Services provided on a non-discriminatory basis **10/26/23**