HOWELL COUNTY HEALTH DEPARTMENT 2024-2025 INJECTABLE INFLUENZA CONSENT FORM

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
EMAIL ADDRESS:	IF UNDER 18, LIST EMERGENCY CONTACT INFO NAME: RELATIONSHIP: PHONE: DOB:

DO YOU HAVE INSURANCE? ☐ **YES** ☐ **NO**
IF YES, NAME OF INSURANCE **POLICY #**

DO YOU HAVE MEDICAID? ☐ **YES** ☐ **NO** **DCN#** **MEDICAID CARRIER**

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

The following questions help us determine if there is any reason we should not vaccinate you today. If you answer "yes" to any question, it does not necessarily mean you will not be vaccinated. It just means additional questions must be asked.

		YES	**NO**
1.	Is the person to be vaccinated sick today?	☐	☐
2.	Does the person to be vaccinated have allergies to medicine, food, a vaccine component or latex?	☐	☐
	If yes, please list:		
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 Guillain-Barre syndrome?	☐	☐

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 VIS (08/06/2021)

ADMINISTRATOR INITIALS	Barcode: _____	Site: ___LD ___ RD ___ LL ___ RL Other _____
KS CC BM MC DA	Date _____ / _____ / _____	**VAXCARE VFC 317 AP**

"AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER"
Services provided on a non-discriminatory basis **8/27/24**