

2018-19 Flu Vaccination Consent Form

PATIENT NAME (LAST, FIRST, MI):	GRADE: _____ TEACHER: _____
DOB: _____ AGE: _____	GENDER: ___ MALE ___ FEMALE
MAILING ADDRESS: _____	PHONE: _____
CITY _____	FOR PATIENTS UNDER 18 YEARS OLD:
STATE, ZIP _____	PARENT/GUARDIAN(S) NAME (LAST, FIRST, MI) _____

Flu Vaccine Preference: Flu Shot _____ Nasal Mist _____ (Note: must be between 2 and 49 without respiratory problems or pregnancy to receive nasal mist- *please read Vaccine Information Statement*)

PLEASE MARK THE APPROPRIATE BOX	Yes	No
1) Are you sick today?	_____	_____
2) Have you ever had a flu shot or flu mist? If YES, When? _____	_____	_____
3) Are you allergic to eggs, egg products or a component of the flu vaccine?	_____	_____
4) Have you ever had a serious reaction to the flu shot or flu mist?	_____	_____
5) Do you or anyone in your household have a weakened immune system?	_____	_____
6) Do you have a history of Guillain-Barre Syndrome?	_____	_____

For those who are considering the **FLU NASAL MIST** please continue on

7) Do you have a long term heart, kidney, liver or nervous system problems?	_____	_____
8) Are you a child or teen receiving aspirin or aspirin-containing therapy?	_____	_____
9) Have you received any other vaccinations in the past four (4) weeks ?	_____	_____
10) Are you pregnant or plan to become pregnant within the next month?	_____	_____
11) Are you receiving antiviral medications within 48 hours?	_____	_____
12) Do you have asthma, wheezing episodes or other breathing problems?	_____	_____

CONSENT FOR VACCINE ADMINISTRATION:

Patient/ Guardian Signature _____ **Date** _____

For Nurse Use Only

DATE	ITEM CODE	LOT #	VACCINE ADMIN SITE	VACCINATOR INITIALS
10/17/18	FLU-Prefilled Syringe (0.5 ml)	UI986AA	RA LA	
	FLU-Prefilled Syringe (0.25ml)	UT6290KA	RT LT	
	FLU MIST	UT6262MA	NASAL	
		KJ3195		

Vaccine Information

<http://harlem-hs.k12.mt.us/>

www.cdc.gov/flu

Insurance, Payment and VFC Eligibility Screening

Please select ONE of the following:

IHS Eligible

Privately Insured, Medicare, Healthy Montana Kids: We bill the insurance company. Make no payment at this time but note you may be responsible for the portion unpaid by the insurance company.

Please provide a copy of both sides of the insurance card at time of service.

Subscriber name _____

Subscriber birth date _____

Insurance carrier (company) _____

Policy # _____ Group # _____

Medicaid, HMK Plus or Uninsured: If patient is a child (under 19), and in one of these categories, he/she qualifies for the Vaccine for Children (VFC) program. You will pay only the administration fee. No child will be denied vaccination because of inability to pay.

Name _____ DOB _____ Medicaid # _____

Self pay: Please pay at time of service. Make checks payable to BCHD (Blaine County Health Department).

Billing Notes (OFFICE USE ONLY):