2021-22 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
	FLU-Prefilled Syringe (0.5 ml) **FLU-Prefilled Syringe (0.25ml)** **FLU MIST**		**RA LA** **RT LT** **NASAL**	

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).

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Billing Notes (OFFICE USE ONLY):