Date of Service: _____

# Influenza Vaccine Consent

**Name:** _____ **Date of Birth:** _____

**SS#:** _____ **Medicaid # (if applicable):** _____

**Address:** _____ **City:** _____ **Zip:** _____

**Insurance Plan:** _____ **Policy #:** _____ **Group #:** _____

***Please check which answer applies if the patient is 17 years of age or younger***

___ he/she is enrolled in Medicaid ___ he/she has insurance, but it does not cover vaccinations

___ he/she has no insurance ___ he/she is an Alaskan Native or Native American ___ none of the above

***Please circle which answer applies:***

| | | | | |
|---|---|---|---|---|
| **1.** | Are you sick today? (Do not include mild cold symptoms or seasonal allergies.) | ***Yes*** | ***No*** | ***Unsure*** |
| **2.** | Have you ever had a serious reaction to chicken eggs including: hives, swelling of the lips or tongue, or difficulty breathing? | ***Yes*** | ***No*** | ***Unsure*** |
| **3.** | Have you ever had a serious reaction after receiving a previous dose of an influenza vaccine? | ***Yes*** | ***No*** | ***Unsure*** |
| **4.** | Have you ever had a serious reaction after receiving a vaccine? | ***Yes*** | ***No*** | ***Unsure*** |
| **5.** | Have you ever been diagnosed with heart disease, lung disease, asthma, kidney disease, metabolic disease (diabetes), anemia, or other blood disorder? | ***Yes*** | ***No*** | ***Unsure*** |
| **6.** | I have been diagnosed with leukemia, AIDS, or any other immune system problem? | ***Yes*** | ***No*** | ***Unsure*** |
| **7.** | Do you take cortisone, prednisone, other steroids, or anticancer drugs; or had x-ray treatments? | ***Yes*** | ***No*** | ***Unsure*** |
| **8.** | Have you had a seizure, brain, or other nervous system problem? | ***Yes*** | ***No*** | ***Unsure*** |
| **9.** | During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin? | ***Yes*** | ***No*** | ***Unsure*** |
| **10.** | **Females:** Are you pregnant or is there a chance you could become pregnant in the next month? | ***Yes*** | ***No*** | ***Unsure*** |
| **11.** | Have you received any vaccinations in the last 4 weeks? | ***Yes*** | ***No*** | ***Unsure*** |
| **12.** | Are you 50 years or older? | ***Yes*** | ***No*** | ***Unsure*** |

## *Please Read and Sign Below*

I have been given a copy of and have read or have had explained to me the information in the "Vaccine Information Statement(s)" for the influenza vaccine. I have had the opportunity to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the flu vaccine. I agree to allow Jordan Valley Community Health Center to communicate with the school district, health care provider, or health department regarding vaccination received if needed. I also agree that vaccinations received may be entered into MOHSAIC, the computerized immunization database for the state of Missouri.

**Signature**: _____ **Date:** _____

*(Signature of person authorized to make request for immunization)*

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**Staff to Complete this Section**

**Manufacture & Lot #:** _____ **Exp Date:** _____ **Shot Location: Deltoid Left Right**

**Consent Signed:** _____ **VIS Sheet Given:** _____ **Staff Initials/Title:** _____ **Date & Time Given:** _____