Flu Vaccine Consent Form

WF17.18

☐ VFC
☐ SF
☐ Private

For Staff Use Only
Eligibility Code: _____

Patient Demographic Information

Patient Name: _____ ☐ M ☐ F
First , Last , M.I.

DOB: _____ **Age:** ____
mm dd yyyy

SSN: _____

Mailing Address: _____

Apt #: _____

City: _____ **State:** _____ **Zip:** _____

Maiden Name: _____

Phone: _____

Physician: _____

Email: _____

Race: ☐ White ☐ American Indian ☐ Multiracial ☐ Other_____

✹ MSU Student? ☐ Yes Please include permanent address below

Permanent Address:_____

City: _____ **State:** _____ **Zip:** _____

Parent Information/Guardian: (Required for all patients under 18 years of age)

Parent/Guardian Name: _____ **Parent/Guardian DOB:** _____

Parent or Guardian SSN: _____

Payment Information

☐ **Insurance** ☐ **None/Self Pay** ☐ **Employer is paying/Name of Employer:**_____

Name of Insurance: _____ ID#: _____ Group#: _____

Subscriber's Name: _____ DOB: _____ Relationship to Patient: _____
Address:_____City:_____ST____Zip_____

Acknowledgement and Consent

ALL PATIENTS/ Parents/Guardians: Please check each box and sign/date the signature box below.

☐ I have read or have had explained to me the information contained in the Vaccine Information Statement(s) about the disease(s) and the vaccine(s). I have had a chance to ask questions which were answered to my satisfaction.

☐ I understand the benefits and risks of the vaccine(s) and request the vaccine(s) to the person named above for whom I am authorized to make this request.

☐ I have received and reviewed the Notice of Privacy Practices, which provides a description of information uses and disclosures.

☐ I consent to the shared use of demographic information and authorize my immunization records to be recorded into the State of Montana Immunization Registry for immunization health purposes and that it may be released to health care providers, childcare providers and schools across the state that may provide continuing immunization services. I understand that I can revoke this authorization and have my record removed at any time by contacting my local county health department.

☐ I authorize payment of medical benefits to this county health department for services rendered. I understand that the patient or parent/guardian is responsible for any unpaid balances. I understand that any unpaid balance may be sent to a collections agency.

☐ I understand that if I am traveling for an extended period of time and will not be able to receive communication from the health department regarding a balance on my account, I must designate a responsible party to pay any unpaid balance. I understand that I still maintain full responsibility for the payment of the bill, regardless of this designation.

Signature: _____ **Date:** _____

Please Answer The Health Questions On The Back

Patient Name: _____ **DOB:** _____ /_____ /_____

HEALTH QUESTIONS

PLEASE READ CAREFULLY AND CHECK YES OR NO.
THE NURSE WILL DISCUSS ANY YES RESPONSES WITH YOU.

IS THE PERSON RECEIVING THE IMMUNIZATIONS:				
✱Do you have allergies? If yes, please list: _____	☐	Yes	☐	No
✱ Do you have allergies to eggs? If yes, describe your reaction: _____ _____	☐	Yes	☐	No
✱Have you ever been diagnosed with Guillain-Barre' syndrome?	☐	Yes	☐	No
✱Do you have long-term health problems with? ☐Heart disease ☐Kidney disease ☐Metabolic disease, such as diabetes ☐Lung disease ☐Asthma ☐Anemia ☐Other blood disorders	☐	Yes	☐	No

For Staff Use Only

Clinic Date: _____ **Nurse Signature:** _____ **Recall Date:** _____

Vaccine	Lot Number	Dose	Site
Flu Shot			LDIM RDIM
High Dose Flu Shot 65 plus			LDIM RDIM

Comments: