Grundy County Health Department

Influenza Consent & History

Clear Form | Print Form

Name	Today's Date
Address	
City / State / Zip	Phone
Date of Birth	Age
Gender Male ☐ Female ☐	

Billing Information

Medicare / Medicaid **OR** **Private Insurance**

Medicare / Medicaid Number	Insurance Company
	Member ID Number
I am eligible for Medicare Part B or Medicaid. My signature below indicates that I have given the Grundy County Health Department permission to bill for the influenza vaccination that I have received today and to release information that may be necessary to process that claim.	Group Number
	Policy Holder's Name
	Policy Holder's DOB

If you are not covered by Medicare, Medicaid, or Private Insurance, please make a donation.

I have been given a copy and have read, or had explained to me, the information in the "Vaccine Information Statement(s) for the vaccine(s) indicated above. I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) for which I have signed below be given to me or the person named above for whom I am authorized pursuant to Section 431.058 RSMo to make this request.

_____

Signature

Turn over and answer all screening questions →

Name

Screening Questions

Are you pregnant?

YES ☐

NO ☐

Due Date:

Are you allergic to eggs? *(Flu vaccine contains a limited quantity of egg protein.)*

If you have a severe egg allergy (hives, swelling of the lips or tongue, acute respiratory distress, or collapse), you should mark **YES**.
If you can eat eggs, you may mark **NO**.

YES ☐

NO ☐

Have you ever been diagnosed with Guillian-Barre Syndrome (GBS)?
(Guillian-Barre is a rare inflammatory disorder.)

YES ☐

NO ☐

Have you had any serious problems with the flu shot before?

YES ☐

NO ☐

Are you sick today? *(There is no evidence that acute illness reduces vaccine effectiveness or increases the likelihood of adverse vaccine reactions.)*

If you have a **MINOR** illness without fever, you may mark **NO**.
If you have an acute illness with a high fever, you should mark **YES**.

YES ☐

NO ☐

FOR HEALTH DEPARTMENT USE ONLY

VIS Given: XX	**VIS Revision Date:** 08/15/2019
Injection Site:	**Expiration Date:**
Manufacturer & Lot Number:	
Signature of Administrator:	

Print Form