FREMONT COUNTY DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT
201 N. 6th Street
Cañon City, CO 81212
P: 719-276-7450 F: 719-276-7451

Influenza Vaccine Consent Form

Name: _____ Date of Birth: _____ M: _____ F: _____
Phone #: _____ Type of Phone (Circle one): Home Cell Work
Address: _____ City: _____ State: _____ Zip: _____

You should <u>not</u> receive the Influenza vaccine if any of the following apply:

- You have ever had a serious allergic reaction to eggs or to a previous dose of influenza vaccine.
- You have a history of Guillain-Barre Syndrome (GBS).
- You are ill.

<u>QUESTIONS</u> (REQUIRED)	**<u>CIRCLE YOUR RESPONSE</u>**
Do you Feel ill today or have a fever?	Yes / No
Are you allergic to egg or egg product?	Yes / No
Have you ever had a severe reaction to a flu vaccine?	Yes / No
Have you ever had Guillain-Bare Syndrome?	Yes / No
Are you allergic to Latex?	Yes / No
If you are female, are you pregnant?	Yes / No / NA
If for a child, has a flu vaccine been received in the past?	Yes / No / NA

<u>INSURANCE/PAYMENT INFORMATION</u>- (You do not need to provide insurance for the drive through clinic)

No Insurance (NI) [ ] Alaska Native (AN) [ ] American Indian (AI) [ ]

Medicare #: _____ Medicaid #: _____

Private Insurance Name: _____

Member ID #: _____ Group/Plan: _____

Subscriber's Name: _____ Subscriber's DOB: _____

By signing below, I hereby authorize Fremont County Department of Public Health & Environment to bill my insurance for reimbursement and request that payment of authorized benefits be made to Fremont County Department of Public Health & Environment.

I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Sheet. I have had a chance to ask questions and they were answered to my satisfaction. **I attest that the above information is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health.** I understand the benefits and risks of each vaccine requested and ask that the vaccine be given to me. I understand that it will not be fully effective for approximately two weeks. However, as with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I understand that one should not receive this vaccine if they have a severe allergy to eggs, have had a severe reaction to a previous influenza vaccine, or if they have had Guillain-Barre Syndrome.

Patient/Parent Signature: _____ Date: _____

****If you feel like you may be having an allergic reaction and are in your car, please pull over and get medical help****

<u>FCDPHE OFFICE USE ONLY</u>

Manufacturer: _____ Lot #: _____ VIS Date: _____
Dose: 0.25cc_____ 0.5cc _____ Injection Site: _____
Administered By: _____ Date: _____