2016/2017

CONSENT FOR VACCINATION

Full Name (last, first, middle initial): _____

Address: _____ **City:** _____ **Zip:** _____ **Phone #:**_____

Birth Date: _____ **Age:** _____ **Male** ___ **Female** ___

SHOT _____ **Social Security Number:** _____

I give permission for HCMH/HCPH to update Iowa's Immunization Registry Information System (IRIS). This will show your doctor that you had a flu shot. **Yes** _____ or **No** _____

Please check one of the following payments:

_____**Medicare ID#** (Write # and **Include Proper Letter**) _____

_____**Bill my health insurance** Policy ID#: _____

Policyholder name: _____ Policyholder birth date: _____

Group name and number: _____ Insurance Company Name: _____

_____ **(initials)** I request that HCMH bill my insurance company for this service, and authorize payment of benefits by my insurance company be made directly to Humboldt County Memorial Hospital.

_____ **Bill Business** _____ **Amount to bill** _____

_____ **Private Pay** **Clinic Location** _____

For Children 6 months Through 18 years: Please fill in this section also.

Has child ever had a flu shot/mist? ___

Please mark one of the following:

_____*6 mo to 18 yrs and on Title 19/Medicaid*

_____*Has no health insurance*

_____*Has health insurance that does not cover immunizations*

_____*Has health insurance that covers* immunizations

____ *American Indian or Alaska Native heritage*

OFFICE USE ONLY:

_____**Medicare**

_____**Insurance**

_____**Bill Business**

_____**Private Pay**

_____**VFC eligible**

Payment Received:
__ Cash __Check # _____

I have read the vaccine information statements or have had it explained to me. I have had the chance to ask questions and these have been answered to my satisfaction. I understand the benefits and the risks of the vaccine and consent to receive it. I accept responsibility for seeking medical attention for any problems with the vaccination. I understand that this vaccine in some people may cause flu-like symptoms and in rare incidents Guillain–Barre Syndrome. **I am consenting to flu vaccine.**

YES	NO	
___	___	I have had a severe (anaphylactic) reaction to a flu shot/mist.
___	___	I am allergic to eggs, thimerosal-containing products (eye contact lens solution), mercury containing products, gentamicin, or neomycin.
___	___	I am moderately or severely ill at this time.
___	___	I have a history of Guillain-Barre Syndrome (GBS).
___	___	I have an allergy to latex (if yes, tell the nurse before vaccination).

Signature: _____Today's Date: _____

FOR NURSES ONLY: Vaccine Administration Record

INFLUENZA VACCINE

IM / High dose IM / Intradermal / Intranasal Site: RD / LD / intranasal / R thigh / L thigh

Mfg/Lot#_____ **Date:** _____ **Administered by:** _____

Do they need to return for dose # 2? YES___ NO___ If yes, tell them to schedule 2nd dose appt.

___ Billing Complete ___ IRIS Entry Complete