Boone County Health Center FLU VACCINATION Consent Form

PLEASE PRINT CLEARLY.

LAST NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____

CITY:_____

STATE:_____ ZIP:_____

PHONE NUMBER: _____

DATE OF BIRTH:_____

MALE: (☐) FEMALE: (☐)

I hereby authorize Boone County Health Center to administer the flu vaccination to me or my child. I understand that sometimes systemic adverse reactions occur and that the most frequent side effect of the vaccine is soreness at the vaccination site. I also understand that because influenza vaccine contains only non-infectious viruses, it cannot cause the flu. I also understand that it takes 2 to 4 weeks for my immune system to build up protection.

By signing, I agree to the following:

1. I have not had a severe life threatening allergy including a severe allergy to eggs.
2. I have not had a severe reaction after a dose of influenza vaccine.
3. I do not have a past history of Guillian-Barre Syndrome.
4. I am not currently ill with an acute respiratory infection or other febrile illness.

Insurance Submission: By signing, I understand that it is my responsibility to know if my insurance provider covers the flu vaccination. If applicable, I authorize Boone County Health Center to submit to my insurance. If my insurance provider does not cover the cost of my vaccination, it is my responsibility.

PATIENT SIGNATURE OR PARENT/GUARDIAN:_____DATE:_____

Boone County Health Center use only:

[ ] Client Bill
[ ] Self- Pay
[ ] Insurance Submission

Employer: _____
Cash/Check #: _____
Insurance Carrier: _____

FIN Number: _____

☐ Fluzone Quad ☐ Fluzone HD

☐ .25ml ☐.5ml

Lot #: _____

Exp Date: _____ Admin Site: LD RD

Date Given: _____

Administer Initials: _____