Boone County Health Center
Dedicated. Caring. Here.

FLU VACCINATION Consent Form

PLEASE PRINT LEGIBLY.

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.

PAYMENT ELECTION:

[ ] Self- Pay
By signing, I either ensure that I have no insurance, or I elect to not submit these charges to my insurance. I agree to pay the discounted self-pay price of either $35 for the normal dose flu shot or $75 for the high dose flu shot.

[ ] Insurance Submission (attach copy of insurance card)
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.

PATIENT SIGNATURE OR PARENT/GUARDIAN:_____DATE:_____

Boone County Health Center use only:

[ ] Client Bill
[ ] Self- Pay
[ ] Insurance Submission
FIN Number: _____

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

☐ Fluzone Quad ☐ Fluzone HD
☐ .25ml ☐.5ml
Lot #: _____
Exp Date: _____ Admin Site: LD RD
Date Given: _____
Administer Initials: _____