

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. NO form of Medicaid will be accepted.

**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: _____