Flu Assessment Screening and Consent Form

PLEASE ATTACH A COPY OF FRONT AND BACK OF INSURANCE CARD

VFC **Emp. Bill** _____ **Insurance** **CK / Cash / CC** _____ **CK / Cash / CC** _____

First name: _____ Last name: _____ Age: _____

SS # _____ Date of birth: _____ Gender: _____ Race: _____ Hispanic or Non

Home address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Insurance Plan: _____

Insurance Id Number: _____ Group #: _____

If covered under your parent/spouse's plan (their name): _____

DOB: _____ **Gender:** _____ **Relationship to you:** _____ **Phone:** _____

Please answer the following questions, even if you're getting the Flu Mist

- Is the person to be vaccinated sick today (fever, cough, nausea/vomiting)? Yes or No
- Does the person to be vaccinated have an allergy to a component of the vaccine? Yes or No
- Has the person to be vaccinated ever had Guillain-Barre Syndrome? Yes or No
- Has the person to be vaccinated ever had a serious reaction to flu vaccine in the past? Yes or No

Flu Mist Only (Ages 5 -18 years)

- Has the person to be vaccinated ever been told they have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease or metabolic disease (e.g., diabetes)? Yes or No
- Do they have a weakened immune system due to HIV/AIDS or any disease that effects immune system, long term use with drugs such as steroids, cancer treatment with radiation or medications? Yes or No
- Does the person to be vaccinated have a cochlear implant, spinal fluid leak or no spleen; have cancer, leukemia, HIV/AIDS, or other immune problems? Or in the past 3 months, have they taken medications that affect the immune system (prednisone or other steroids, treatment for arthritis, Crohn's disease, psoriasis or anticancer drugs or radiation treatments)? Yes or No
- Is the person being vaccinated currently taking any influenza antiviral medications or taken any in the last 3 weeks? Yes or No
- Is the person being vaccinated receiving aspirin therapy or aspirin containing therapy? Yes or No
- Does the person being vaccinated live with or expect to have close contact with anyone whose immune system is severely compromised and who must be in protective isolation (i.e. bone marrow transplant)? Yes or No
- Has the person to be vaccinated received any immunizations in the past 4 weeks? Yes or No
- Is the person to be vaccinated pregnant or do they plan to become pregnant in the next 4 weeks? Yes or No

Please Read and Sign Below

This record will be kept on file at the Macon Co. Health Dept. It will record when the vaccine was given, the name of the manufacturer, the lot number and injection site. I have read and been offered a copy of the **V**accine **I**nformation **S**tatement and have had the opportunity to ask questions and had them answered to my satisfaction. I understand the benefits and risk of the vaccine to be given and give my consent to receive the injection. I give consent for my insurance (if applicable) to be billed, and if denied, I understand that I am responsible for the payment in full. By signing below, I acknowledge that I have been offered a copy and/or read the HIPAA Privacy Act and agree to the statements above.

Signature: _____ **Date:** _____

(I give permission for 1st and 2nd dose, if a 2nd dose is required)

Staff Use Only: Eligibility verified by Online or Phone (initials) _____ Date: _____

Rev. 10/23

<u>High Dose</u> (65 +) **Date given: ____________________**

Sanofi Pasteur Lot # Exp. Date: 6/30/2024 VIS date: 8/6/21 STICKER
Lot # Exp. Date: 6/30/2024

Administered by: ______________________________ Injection site: Rt Lt deltoid

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<u>FluBlok</u> (18 +) – Rec. (40-64) **Date given: ________________________**

Sanofi Pasteur Lot # Exp. Date: 6/14/2024 VIS date: 8/6/21 STICKER
Lot # Exp. Date
Lot # Exp. Date

Administered by: ____________________________ Injection site: Rt Lt deltoid

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<u>Fluzone .5</u> (6m - 40) **Date given: ________________________**

Sanofi Pasteur Lot # Exp. Date: 6/30/2024 VIS date: 8/6/21 STICKER
Lot # Exp. Date:

Administered by: ____________________________ Injection site: Rt Lt deltoid thigh

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<u>Flu Mist</u> (5-18) **School age only** **Date given: ________________________**

AstraZeneca- **INSURANCE** Lot # Exp. date: VIS date: 8/6/21
Lot # Exp. date:

STICKER

VFC Lot # Exp. Date:

Administered by: ____________________________ Route: Intranasal

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<u>Fluarix .5</u> (6m - 40) **School only first** **Date given: ________________________**

GSK **INSURANCE** Lot # Exp. date: 6/30/2024 VIS date: 8/6/21 STICKER

VFC Lot # Exp. Date:

Administered by: ______________________________ Injection site: Rt Lt deltoid thigh

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Fluarix 317 (19 +) **No Insurance** **Date given: __________________________**

GSK Lot # Exp. Date: VIS date: 8/6/21 STICKER

Administered by: ______________________________ Injection site: Rt Lt deltoid