FREMONT COUNTY DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT

Phone: 719-276-7450 | 201 N. 6th Street, Cañon City, CO 81212 | Fax: 719-276-7451

Influenza Vaccine Consent Form 2023-2024

PATIENT INFORMATION

Patient's Name: (Last) _____ (First) _____ (MI) _____

Address:_____ City, State, Zip: _____

Phone: _____ DOB: _____ Sex: ☐ Female ☐ Male ☐ Other_____

Emergency Contact: Name:_____

Relationship to Patient:_____ Phone #:_____

VACCINE QUESTIONAIRRE

1. Is the patient ill today or have a fever? Yes / No
2. Has the patient ever had a serious reaction after receiving a flu vaccine? Yes / No If yes: _____
3. Does the patient have an allergy to food, egg or egg product? Yes / No If yes: _____
4. Has the patient ever had Guillain-Barre Syndrome? Yes / No
5. Is the patient allergic to Latex? Yes / No
6. Is the patient pregnant or is there a chance they could become pregnant during the next 4 weeks? Yes / No / NA
7. If the patient is a child, has the patient received a flu vaccine in the past? Yes / No / NA If yes: _____

INSURANCE INFORMATION

We recommend that you check with your health plan prior to receiving any medical services to assess your benefits and eligibility for coverage.

☐No Insurance ☐Medicaid ☐Medicare ☐Private Insurance Name: _____

Policy #:_____ Group #:_____

(only if different than patient) Subscriber Name :_____Phone:_____

Address, City, State, Zip: _____ SSN:_____-____-_____

You should not receive the Influenza vaccine if any of the following apply:

- **You have ever had a serious allergic reaction to eggs or to a previous dose of influenza vaccine.**
- **You have a history of Guillain-Barre Syndrome (GBS).**
- **You are ill.**

FINANCIAL POLICY

By signing below, I hereby authorize Fremont County Department of Public Health & Environment to disclose any portion of the patient's medical record necessary to my insurance for reimbursement of services and request that payment of authorized benefits be made to Fremont County Department of Public Health & Environment.

VACCINE CONSENT

I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Sheet. I have had a chance to ask questions and they were answered to my satisfaction. I attest that the above information is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health. I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me. I understand that it will not be fully effective for approximately two weeks. However, as with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I understand that one should not receive this vaccine if they have a severe allergy to eggs, have had a severe reaction to a previous influenza vaccine, or if they have had Guillain-Barre Syndrome.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

FCDPHE OFFICE USE ONLY

Manufacturer: _____ Lot #: _____VIS Date: _____

Dose: 0.25cc_____ 0.50cc _____ 0.70cc_____ Injection Site: _____

Administered By: _____ Date: _____