INFLUENZA VACCINATION CONSENT (*Please Print*)

SCHOOL_____ **GRADE**_____**TEACHER**_____

LAST NAME _____FIRST NAME_____MIDDLE _____
ADDRESS _____CITY _____ STATE _____ ZIP _____
BIRTHDATE _____/_____/_____ AGE_____ SEX_____ RACE_____
Parent/Guardian Information
LAST NAME _____FIRST NAME _____PHONE (_____) _____

_____**ELIGIBLE FOR FREE VFC VACCINE BECAUSE: (*check one*)**

____**Medicaid** *Please give ID #*_____

____**American Indian/Alaskan Native ***

____**No Health Insurance ***

____**Insurance Does Not Cover Vaccines ***

***** Attach $20 cash, or a check made payable to *"JCHD"* to cover the administration fee, ***OR***

* Check box if you are unable to pay the fee.

☐ **I am unable to pay the $20.00 administration fee**

Note: Medicaid patients do NOT need to pay administration fee, or check the box. This only applies to those who are either American Indian/Alaskan Native, No Health Insurance, or Insurance Does Not Cover Vaccines.

_____**INSURED**

Circle company name and fill in policyholder information

Aetna Anthem Cigna Encore Humana MedBen Sagamore Siho TriCare United Healthcare

POLICY HOLDER NAME:_____**ID#**_____

_____**PAY FOR SERVICES WITH CASH OR PERSONAL CHECK**

Make check payable to *"Jefferson County Health Department".*

$20.00 Influenza Vaccine

HEALTH SCREENING: ***Answer all questions about the child receiving the vaccine.***

Yes No Does the child have any allergies to eggs or any component of the influenza vaccine?
Yes No Has the child had a serious reaction to the influenza vaccine in the past?
Yes No Has the child ever had Guillain-Barré Syndrome?

I have read the VIS statement (8-7-15) for the vaccine to be administered and understand the benefits and risks of the vaccine.
I authorize the staff of JCHD to administer the Influenza vaccine to the person named above.
I acknowledge receipt of the "Notice of Health Information Privacy Practices". *(Paper copy available at JCHD)*
If applicable, I authorize JCHD to bill my health insurance and request payment of authorized insurance benefits be made directly to JCHD. I understand if insurance does not cover services that I will be responsible for payment of these services.

SIGNATURE *(Parent/Guardian if patient under 18 yrs)* _____**DATE** _____

FOR OFFICE USE ONLY

INFLUENZA:

VFC

90686 FLUZONE
3 yrs and over, quadravalent PF Sanofi
Route: Intramuscular U58896DA
Site: R Arm L Arm Exp. 06/30/18

90686 FLUAVAL
6mos and older, quadravalent PF GSK
Route: Intramuscular 4ES32
Site: R Arm L Arm Exp. 05/31/18

PRIVATE

90688 FLUAVAL GSK
6 mos and older, quadrivalent 7929M
Route: Intramuscular Exp: April 2018
Site: R Arm L ARM

Date Administered_____ **Vaccinator Signature**_____