☐ **High Dose** (65 & Over) ☐ **FluBlok** (18 & Over) ☐ **Fluzone** (6 mo. & Over) ☐ **VFC Fluarix** (6 mo. & Over)

(For Office Use Only) Put P for Public in the right corner in red ink

Doniphan Co. Health Dept./Home Health
2021-2022 Seasonal Flu Vaccination Consent Form

Print the NAME of the person receiving the vaccination: _____

If client is a MINOR, name of parent or guardian: _____

Date of Birth: ____/____/____ **Age:** _____ **Sex:** ☐ **Male** ☐ **Female** **Phone Number:** _____

Mailing Address: _____ **City:** _____ **Zip:** _____

Primary Care Physician: _____

Primary Insurance Information: Please provide the information:

NAME of Policy Holder exactly as it appears on the insurance card: _____

Name of Insurance Company: _____

Insurance member policy # _____ **Group #** _____

KanCare: ☐ **Sunflower** ☐ **Aetna** ☐ **United** **Card #** _____

Immunization Screening Questionnaire

1. **Is the person to be vaccinated currently sick or experiencing high fever?** ☐ **Yes** ☐ **No**
2. **Does the person to be vaccinated have a history of Guillain Barre' Syndrome?** ☐ **Yes** ☐ **No**
   (A Syndrome in which the body damages its own nerve cells resulting in weakness and sometimes paralysis.)
3. **Is the person to be vaccinated ever had a serious allergic reaction to eggs?** ☐ **Yes** ☐ **No**
4. **If the person receiving a flu shot is under 9 years of age, did he/she have the flu shot in the past?** ☐ **Yes** ☐ **No** ☐ **NA**
5. **Have you ever had a serious reaction to a previous dose of the flu vaccine?** ☐ **Yes** ☐ **No**

*I have been offered or provided, whether accepted or not, a copy of the "**Vaccine Information Statement(s)**." I have read, or have had explained to me, the information in the "Vaccine Information Statement(s)". My questions have been answered satisfactorily, and I ask that the flu vaccine be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below.*

The Doniphan County Health Department/Home Health Agency *can bill my insurance for any services rendered as applicable.* I understand I *will be responsible for any services provided which my insurance does not cover.* ALL INFORMATION IS CONFIDENTIAL I certify that the above information is correct to the best of my knowledge. I authorize release of immunization records for the patient listed above to any licensed physician, primary care provider, local health department, educational institution, or regulated child/adult care facility. I understand any other health information for the patient listed above will not be released without written authorization from the patient's responsible party. I acknowledge that I have received a copy of the Agency's Notice of Privacy Practices with the effective date of February 4, 2016. This agreement is valid for one year for all services provided by Doniphan County Health Dept. Home Health.

X _____ _____

Signature of Patient or Parent/Guardian Date

PROVIDER INFORMATION					
Vaccine Provider: Doniphan Co. Health Dept./Home Health Agency			Clinic Site: DPCOHD		
Street Address: 201. S. Main -PO Box 609, Troy	State KS	Zip Code 66087	Street Address: 201 S. Main Street, Troy	State KS	Zip Code 66087

(Circle the appropriate vaccine, dose, extremity, site, route, and write in the manufacturer, lot #, and expiration date)

FOR CLINICAL USE ONLY							
Vaccine	**Dose**	**Ext.**	**Site**	**Route**	**VIS Date**	**Manufacturer Lot # Exp. Date**	**Notes**
High Dose Quad	**0.5cc 1**	**RT LT**	Deltoid Vastus Lat	IM	8/6/2021	**Sanofi**	
FluBlok Quad	**0.5cc 1**	**RT LT**	Deltoid Vastus Lat	I M	8/6/2021	**Sanofi**	
Fluzone Quad	**0.5cc 1 2**	**RT LT**	Deltoid Vastus Lat	IM	8/6/2021	**Sanofi**	
Fluarix VFC	**0.5cc 1 2**	**RT LT**	Deltoid Vastus Lat	IM	8/6/2021	**McKesson**	

X_____ _____

Signature and Title of Vaccine Administrator **Date**