

**High Dose**  
(65 & Over)

**FluBlok**  
(18 & Over)

**Fluzone**  
(6 mo. & Over)

**VFC Fluarix**  
(6 mo. & Over)



Health Dept./Home Health  
Prevent. Promote. Protect.

## Doniphan Co. Health Dept./Home Health 2022-2023 Seasonal Flu Vaccination Consent Form



### Person Receiving the Vaccine:

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 Insurance Information: Please provide the information:

**NAME** of Policy Holder **EXACTLY** as it appears on the insurance card: \_\_\_\_\_

**Social Security # of Policy Holder (Required to bill insurance)**: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Insurance member policy # \_\_\_\_\_

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) and a Notice of Privacy Practices (NOPP) dated February 4, 2016." 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.

**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
<b>High Dose Quad</b>	0.5cc 1	RT  LT	Deltoid Vastus Lat	IM	8/6/2021	<b>Sanofi</b>	
<b>FluBlok Quad</b>	0.5cc 1	RT  LT	Deltoid Vastus Lat	IM	8/6/2021	<b>Sanofi</b>	
<b>Fluzone Quad</b>	0.5cc 1 2	RT  LT	Deltoid Vastus Lat	IM	8/6/2021	<b>Sanofi</b>	
<b>Fluarix VFC</b>	0.5cc 1 2	RT  LT	Deltoid Vastus Lat	IM	8/6/2021	<b>GSK</b>	

X \_\_\_\_\_

Signature and Title of Vaccine Administrator

\_\_\_\_\_

Date