☐ **High Dose** (65 & Over) ☐ **FluBlok** (18 & Over) ☐ **Fluzone** (6 mo. & Over) ☐ **VFC Fluzone** (6 mo-18) ☐ **317 Fluzone** (19 and older)

Doniphan Co. Health Dept./Home Health
2023-2024 *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: _____

Name of Insurance Company**:** _____

Insurance Member policy # _____

Name of Secondary Insurance Company & Policy Number: _____

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.

_____ _____

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**	
Fluzone VFC	**0.5cc 1 2**	**RT LT**	Deltoid Vastus Lat	IM	8/6/2021	**Sanofi**	
Fluzone 317	**0.5cc 1**	**RT LT**	Deltoid Vastus Lat	IM	8/6/2021	**Sanofi**	

Signature and Title of Vaccine Administrator **Date**