Itasca County Public Health Form for Flu Vaccine

PLEASE FILL IN ALL OF THE HIGHLIGHTED SECTIONS OF THIS FORM. THANK YOU.

Section 1: Information about person to receive Vaccine (please print)

Name (Last)	(First)	(M.I.)	**Date of Birth** _____ **Age:** ____	**Gender:** M F
Parent/Legal Guardian's Name: (Last)	(First)	(M.I.)	**Mother's maiden name of vaccine recipient:**	
Address			**Daytime Phone**:	
City:	**State:**	**Zip:**	**Cell Phone:**	
Doctor/Clinic:				

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if the person to be vaccinated can get the seasonal flu vaccine. If you answer "No" to all of the questions, the person can get the vaccine. If you answered "YES" to one or more of the following questions, a nurse will follow up to get more information about the situation.

Please check YES or NO for each question below: Please answer the questions for the person being vaccinated.

	Yes	No
1. Did the person to be vaccinated receive the seasonal influenza vaccine last year?		
2. Is the person to be vaccinated sick today?		
3. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?		
4. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?		
5. Has the person to be vaccinated ever had Guillain-Barre syndrome?		

Section 3: Consent

Consent for Vaccination: Please review and sign the following statement.

I have read or had explained to me the current Vaccine Information Statement for the vaccine(s) to be administered and understand the risks and benefits. I give my permission to add this information to the Minnesota Immunization Information Connection (MIIC) (my doctor will then be able access this information). I give consent to the Itasca County Public Health Nurse to vaccinate the person listed at the top of this form with the requested vaccine. **(If this consent form is not signed, then your child will not be vaccinated)**

Signature: Parent/Legal Guardian/Self: _____ Date: _____

Section 4: Vaccination Record **(For Administrative Use Only)**

Vaccine	Route	Date Dose Administered	Dose administered	Date Dose Expired	VIS Date	Date VIS Given	Lot #	Manufacturer
Influenza shot	IM RD LD		0.5mL		08/15/2019			

Signature and title of personnel administering vaccine: _____

---Please turn over and complete the other side---

Section 5: Please check all that apply:

☐ Has no medical insurance

☐ American Indian or Native Alaskan (children 18 years of age and younger only)

☐ Has medical insurance that does not cover the cost of flu vaccines

☐ Has medical insurance that caps vaccine coverage at a certain amount and that amount is reached

If you have checked any of the above: Your cost for the shot is $20.00. *If you are unable to pay you/your child will not be denied any vaccinations.* A donation of any amount is accepted. **(*Make check payable to:*** Itasca County Health Dept.)

If you have NOT checked any of the above: Please complete the following and check what is applicable to your situation.

☐ Insurance Company Name: _____ Policy ID: _____ Group Number: _____

Name of Policy Holder: _____Policy Holder Date of Birth: _____

- MA: #_____
- IMCare: #_____

☐ **You are an ISD 318 employee/retiree/dependent covered by ISD 318 insurance. This is for district 318 only.**

Group Number: _____ ID#_____

***If you have checked any of the above**: Your insurance will be billed for payment.

***If you have not checked any of the above: Your cost for the vaccine is $25.00. (Make check payable to: Itasca County Health Dept.)**

Parent/Guardian/Self signature: _____ Date:_____

Nurse signature: _____ Date: _____

---Please turn over and complete the other side---