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)	**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.

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 (inactivated quadrivalent)	IM RD LD		0.5mL	6/30/2021	08/15/2019			

Signature and title of personnel administering vaccine: _____

Updated 9/25/20

*** No one will be turned away due to inability to pay or lack of medical insurance. The following will help us determine if you or your child are eligible for the *MN Vaccines for Children (MnVFC) Program* or the *MN Uninsured and Underinsured Adult Vaccine Program.***

Section 5: Please check all that apply:

☐ Has no medical insurance

☐ American Indian or Native Alaskan (MnVFC eligibility criteria; 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 has been reached

☐ Has medical insurance, MA, or IMCare that covers flu vaccines

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. <u>This is for District 318 only</u>.**

Group Number: _____ ID#_____

☐ **If you have not checked any of the above: Your cost for the vaccine is <u>$25.00</u> (Please make check payable to: Itasca County Health Department)**

Parent/Guardian/Self Signature: _____ Date:_____

Nurse/Staff Signature: _____ Date: _____

Donations gladly accepted; suggested amount is $20 per shot