Itasca County Public Health Consent Form for Flu Vaccine

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

Public Health
Prevent. Promote. Protect.

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

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

Section 2: Screening for Vaccine Eligibility ***Please check YES or NO for each question below: Please answer the questions for the person being vaccinated.***

	Yes	No
1. Is the person to be vaccinated sick today?		
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?		
3. Has the person to be vaccinated ever had a serious reaction to an influenza vaccine in the past?		
4. Has the person to be vaccinated ever had Guillain-Barre Syndrome?		
5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?		
6. Is the person to be vaccinated anxious about getting a shot today?		

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.

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

Vaccination Record (For Administrative Use Only):

Vaccine	Site	Date Dose Administered	Dose administered	Date Dose Expired	VIS Date	Date VIS Given	Lot # (label from syringe)	Manufacturer (label from syringe)
Fluzone	**IM:** Deltoid: Right Left VastusLateralis: Right Left		0.5mL	6/30/2024	8/6/2021			

Signature and title of personnel administering vaccine: _____ Date: _____

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

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Section 4: Billing Insurance will be billed for this immunization, if applicable. 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 (UUAV).*

Please check all that apply: Read each option, then select as appropriate.

☐ HAS **NO** MEDICAL INSURANCE *(patient will not be billed; donations gladly accepted, suggested amount is $20 per shot)*

☐ AMERICAN INDIAN OR NATIVE ALASKAN (MnVFC eligibility criteria **18 years of age and younger only**) *(patient **<18** will not be billed; donations gladly accepted, suggested amount is $20 per shot)*

☐ HAS MEDICAL INSURANCE THAT DOES **NOT** COVER THE COST OF FLU VACCINES *(patient will not be billed; donations gladly accepted, suggested amount is $20 per shot)*

☐ HAS MEDICAL INSURANCE THAT **CAPS** VACCINE COVERAGE AT A CERTAIN AMOUNT and that amount has been reached *(patient will not be billed; donations gladly accepted, suggested amount is $20 per shot)*

☐ HAS PRIVATE MEDICAL INSURANCE, MA, OR IMCARE THAT COVERS FLU VACCINES, *please fill out all that apply:*

Insurance Company Name: _____

Policy ID: _____ Group Number: _____

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

- **MA: #_____**
- **IMCare: #_____**

☐ IF YOU PREFER US NOT TO BILL YOUR INSURANCE: Cost for the vaccine is **$25.00** (Please make check payable to: Itasca County Health Department)

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

- *Group Number: _____ ID#_____*

Parent/Guardian/Self Signature: _____ Date: _____

Nurse/Staff Signature: _____ Date: _____

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