VFC
PRIVATE

Influenza Vaccination Consent

"I have received and read the Centers for Disease Controls' Influenza Vaccine Information Statement. I have had the chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and ask the vaccine be given to me or the person named below for whom I am authorized to make this request. I understand that members of Cass Health will bill to the insurance coverage(s) provided below, but I am responsible for and will receive a statement for any amount that stated insurance does not cover. I understand that not filling out this form completely, clearly, and correctly may cause incorrect vaccination and billing. I request the influenza vaccine to be administered."

Patient or Parent/Guardian Signature ______________________________ **Date** __________

Name: (Last)	(First)	(M.I.)	School:	Grade:

Address:	**Birthdate:** mm/dd/yyyy	**Age**:	**Gender**: (circle) MALE FEMALE

City:	**State:**	**Zip:**	**Parent Name & Daytime Phone:** Name: Phone:

Physician:	**Physician Office Name/Location:**	**Physician Office Number:**

If you will be receiving the Influenza vaccination, please answer the following questions by circling Yes or No. Parents/Guardians please fill out on behalf of your child.

Is this the individual's FIRST flu vaccination ever?	Yes	No
Has the individual had an allergic reaction to eggs, Gentamicin, gelatin, arginine or a previous vaccination?	Yes	No
Has the individual had Guillain-Barre Syndrome, a severe paralytic illness within six weeks after receiving a flu vaccine?	Yes	No
Does the individual feel moderately or severely ill and/or are they running a fever today?	Yes	No

Payment Method

- ❑ I have no insurance or my insurance does not cover immunizations (vaccination provided at no cost, donations welcome)
- ❑ I am American Indian or an Alaskan Native (vaccination provided at no cost, donations welcome)
- ❑ I have private insurance and want the bill submitted through my insurance plan

Insurance policy holder's name:	Policy holder's DOB:
Policy holder's address: City: State: Zip:	Insurance company name: ❑ Hawki ❑ Medicaid ______________ ❑ Commercial ______________ ❑ No Insurance

Please look at your insurance card to complete the information below. You may provide a copy of your insurance card if you prefer.

Insurance policy number: ______________________ Insurance group number: ____________

For clinic/office use ONLY:

Date vaccine administered: ____________

Name of school: ATLANTIC MASSENA GRISWOLD ANITA

❑ Influenza

Bill to:
- ❑ Hawki
- ❑ Medicaid
- ❑ Commercial
- ❑ No Insurance

Signature/Credentials of Vaccine Administrator: ______________________

❑ Private ❑ VFC

IRIS entry done by: ______________________ Date: ____________