FLU CONSENT FORM

FOR OFFICE USE ONLY - New Patient? ❑Yes ❑No Insurance Verification #:______________Staff________________________

Patient Last Name:____First Name:______________________________________

Gender: ❑M ❑F DOB:______________________Age:__________Daytime Phone:_____________________________

Mailing Address:_____________________________City:________________________________State:_________Zip:__________________

Primary Care Physician:______________________________Ethnicity:_____________________Preferred Language:_________________

❑Commercial Insurance

Insurance Name:____

Policy #:______________________Grp #:____________________

Primary Insured:________________Primary Insured DOB:_________

❑Self Pay

❑Cash $______________________________________

❑Credit ❑Visa ❑MC ❑Discover ❑AmEx

**Please provide card to attendant for processing. A receipt will be provided.*

Name on Card:____

Billing Address: ❑*Same as Mailing*

____

❑Medicaid/Texas Vaccines for Children Program

❑Medicaid Number:____________________Date of Eligibility:_________

OR ❑CHIP Number:_______________________Date of Eligibility:_________

OR ❑American Indian OR Alaska Native

OR ❑Is Underinsured*: (Mark X in one of boxes below)

❑My child has commercial (private) insurance, but coverage does not include vaccines

OR ❑My child's commercial insurance covers only selected vaccines

❑Medicare

Policy Number:____

Flu Vaccine: If you answer "YES" to any of the following questions, you may not be eligible for flu vaccine today. CIRCLE ANSWERS

Question		
1. Have you/your child ever had a serious reaction/sensitivity to any flu vaccines?	YES	NO
2. Have you/your child ever been diagnosed with (Guillain-Barré syndrome)?	YES	NO
3. Do you/your child have an allergy to a component of the vaccine?	YES	NO
4. Have you felt ill today or yesterday or do you have a fever?	YES	NO
5. Child 6 months - 8 years Only: Has your child received at least 2 doses of flu vaccine before July 1, 2019?	YES	NO

Patient Signature: ____

FOR OFFICE USE ONLY-

Clinic stock: - (Circle One): FLUZONE QUAD PEDI (6m- 35m) | FLUZONE QUAD (6m and older) | FLUCELVAX (4yr. and older) | FLUZONE HIGH DOSE (65yr. and older)

State stock: - (Circle One): FLULAVAL QUAD (6m and up) | FLUZONE QUAD (3yr. and up)

Administered By:______________________ Date:_________________ Site of Injection: ❑R ❑L ❑Deltoid Thigh

Lot #:______________________ Seqirus GSK Sanofi Expiration Date: _________________________ NDC #: ______________

VIS Sheet Given? ❑YES ❑NO VIS Date: _________________________________PT MRN:_______________________________