Floyd Valley Community Health

Billing _____
IRIS _____
HM _____

Influenza Vaccine Consent Form

I have been given a copy of the Influenza Vaccine Information Statement. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of Influenza Vaccine and request that this be given to me or to the person named below for whom I am authorized to make this request.

PLEASE PRINT CLEARLY

Full Name _____

Birthdate _____ **Age** _____ ☐ **Male** ☐ **Female**

Street Address _____

City / State / Zip _____ **Phone** _____

Family Physician _____

1. **Do you have a serious allergy to eggs?** **Yes** **No**
2. **Have you ever had an allergic reaction or other problem after a vaccination? (shortness of breath, hives, difficulty breathing, etc.)** **Yes** **No**
3. **Were you ever paralyzed by Guillain-Barre Syndrome within 6 weeks after receiving the influenza vaccine?** **Yes** **No**
4. **Do you feel well today?** **Yes** **No**

Signature X_____ **Date** _____ **Time** _____
(Patient or Parent/Guardian)

For Office Use Only:

☐ **Private Insurance**
Company _____ **Policy #** _____
☐ **Medicare**
Company _____ **Policy #** _____
☐ **Medicaid**
Company _____ **Policy #** _____
☐ **No Insurance/Underinsured** **Employee of:**
☐ **VFC** ☐ **Self-Pay** ☐ **FVH Employee** ☐**City of LeMars**

For Nurse Use Only:

☐ Private-Flulaval Lot# J9HA9
☐ VFC-Flulaval Lot# 7A5C3, 93SS5
☐ Fluad Quad (65 yrs and olders) Lot# 370274
☐ Flublok Lot#

IM injection Site: (circle) RD LD

Date Vaccinated _____ Nurse Signature_____