

# Flu Assessment Screening and Consent Form

VFC    Emp. Bill \_\_\_\_\_    Insurance    CK / Cash / CC \_\_\_\_\_    CK / Cash / CC \_\_\_\_\_

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ Age: \_\_\_\_\_

SS # \_\_\_\_\_ Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Race: \_\_\_\_\_ Hispanic or Non

Home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance Plan: \_\_\_\_\_

Insurance Id Number: \_\_\_\_\_ Group #: \_\_\_\_\_

If covered under your parent/spouse's plan (their name): \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship to you: \_\_\_\_\_ Phone: \_\_\_\_\_

## Please answer the following questions, even if you're getting the Flu Mist

- ❖ Is the person to be vaccinated sick today (fever, cough, nausea/vomiting)?    Yes    or    No
- ❖ Does the person to be vaccinated have an allergy to a component of the vaccine?    Yes    or    No
- ❖ Has the person to be vaccinated ever had Guillain-Barre Syndrome?    Yes    or    No
- ❖ Has the person to be vaccinated ever had a serious reaction to flu vaccine in the past?    Yes    or    No

### **Flu Mist Only (Ages 5 -18 years)**

- ❖ Has the person to be vaccinated ever been told they have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease or metabolic disease (e.g., diabetes)?    Yes    or    No
- ❖ Do they have a weakened immune system due to HIV/AIDS or any disease that effects immune system, long term use with drugs such as steroids, cancer treatment with radiation or medications?    Yes    or    No
- ❖ Does the person to be vaccinated have a cochlear implant, spinal fluid leak or no spleen; have cancer, leukemia, HIV/AIDS, or other immune problems? Or in the past 3 months, have they taken medications that affect the immune system (prednisone or other steroids, treatment for arthritis, Crohn's disease, psoriasis or anticancer drugs or radiation treatments)?    Yes    or    No
- ❖ Is the person being vaccinated now receiving any or recently taken any antiviral medications?    Yes    or    No
- ❖ Is the person being vaccinated receiving aspirin therapy or aspirin containing therapy?    Yes    or    No
- ❖ Does the person being vaccinated live with or expect to have close contact with anyone whose immune system is severely compromised and who must be in protective isolation (i.e. bone marrow transplant unit)?    Yes    or    No
- ❖ Has the person to be vaccinated received any immunizations in the past 4 weeks?    Yes    or    No
- ❖ Is the person to be vaccinated pregnant or do they plan to become pregnant in the next 4 weeks?    Yes    or    No

### **Please Read and Sign Below**

This record will be kept on file at the Macon Co. Health Dept. It will record when the vaccine was given, the name of the manufacturer, the lot number and injection site. I have read and been offered a copy of the Vaccine Information Statement and have had the opportunity to ask questions and had them answered to my satisfaction. I understand the benefits and risk of the vaccine to be given and give my consent to receive the injection. I give consent for my insurance (if applicable) to be billed, and if denied, I understand that I am responsible for the payment in full. By signing below, I acknowledge that I have been offered a copy and/or read the HIPAA Privacy Act and agree to the statements above.

**Signature:** \_\_\_\_\_    **Date:** \_\_\_\_\_

(I give permission for 1<sup>st</sup> and 2<sup>nd</sup> dose, if a 2<sup>nd</sup> dose is required)

**Staff Use Only:** Eligibility verified by    Online    or    Phone (initials) \_\_\_\_\_    Date: \_\_\_\_\_

**High Dose (65 +)**

**Date given:** \_\_\_\_\_

Sanofi Pasteur Lot # UJ716AB Exp. Date: 6/30/22 VIS date: 8/6/21 STICKER

Administered by: \_\_\_\_\_ Injection site: Rt Lt deltoid

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**FluBlok (18 +) – Rec. (40-64)**

**Date given:** \_\_\_\_\_

Sanofi Pasteur Lot # UJ724AA Exp. date: 6/30/22 VIS date: 8/6/21 STICKER

Administered by: \_\_\_\_\_ Injection site: Rt Lt deltoid

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**Fluzone .5 (6m - 40)**

**Date given:** \_\_\_\_\_

Sanofi Pasteur Lot # UT7319JA Exp. date: 6/30/22 VIS date: 8/6/21 STICKER

Administered by: \_\_\_\_\_ Injection site: Rt Lt deltoid thigh

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**Flu Mist (5-18) School age only**

**Date given:** \_\_\_\_\_

AstraZeneca

**Insurance** Lot # NH2014 Exp. date: 12/29/21 VIS date: 8/6/21

**VFC** Lot # Exp. Date:

Administered by: \_\_\_\_\_ Route: Internasal

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**Fluarix .5 (6m - 40) School only first**

**Date given:** \_\_\_\_\_

GSK

**Insurance** Lot # PH7C2 Exp. date: 6/30/22 VIS date: 8/6/21 STICKER

**VFC** Lot #

Administered by: \_\_\_\_\_ Injection site: Rt Lt deltoid thigh

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**Flu 317 (19 +) No Insurance**

**Date given:** \_\_\_\_\_

GSK Lot # Exp. Date: VIS date: 8/6/21 STICKER

Administered by: \_\_\_\_\_ Injection site: Rt Lt deltoid