□ **High Dose** (65 yr & Over) □ **FluBlok** (50 yr & Over) □ **Fluzone** (6 mon & 0ver) □ **VFC Fluzone** (6 mon-18 yr) □ **317 Fluzone** (19 yr and older) □ **Flu Mist** (2 yr-49 yr)

Doniphan Co. Health Dept./Home Health
2025-2026 *Seasonal Flu* Vaccination Consent Form

***Person Receiving the Vaccine*:**

Print the **NAME** of the **person receiving the vaccination:** _____

If client is a **MINOR,** name of parent or guardian**:** _____

Date of Birth: _____ Age: _____ Sex: € Male € Female Phone Number**:** _____

Mailing Address: _____ City: _____ Zip: _____

Race: ☐White ☐Alaskan Native/American Indian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐Asian
☐Decline Ethnicity: ☐Hispanic/Latino ☐ non-Hispanic ☐ Decline to Answer

***Primary Insurance Information*: Please provide the information:**

NAME of Policy Holder **EXACTLY** as it appears on the insurance card: _____

Name of Insurance Company or Medicare**:** _____

Insurance Member policy # or Medicare # _____

Name of Secondary Insurance Company & Policy Number: _____

KanCare: € Sunflower € Healthy Blue € United Card # _____

Immunization Screening Questionnaire

1. Is the person to be vaccinated currently sick or experiencing high fever?	**€ Yes**	**€ No**	
2. Does the person to be vaccinated have a history of Guillain Barre' Syndrome? **(A Syndrome in which the body damages its own nerve cells resulting in weakness and sometimes paralysis.)**	**€ Yes**	**€ No**	
3. Has the person to be vaccinated ever had a serious allergic reaction to eggs?	**€ Yes**	**€ No**	
4. If the person receiving a flu shot is under 9 years of age, did he/she have the flu shot in the past?	**€ Yes**	**€ No**	**€ NA**
5. Has the person to be vaccinated had a serious reaction to a previous dose of the flu vaccine?	**€ Yes**	**€ No**	
6. Has the person to be vaccinated received any other vaccine in the last 4 weeks?	**€ Yes**	**€ No**	
7. Does the person to be vaccinated have issues with asthma, wheezing, COPD, weakened immune system, CHF, chronic kidney problems, diabetes, egg allergy, or pregnant/breastfeeding?	**€ Yes**	**€ No**	

I have been offered or provided, whether accepted or not, a copy of the "**Vaccine Information Statement(s)**and a Notice of Privacy Practices (NOPP) dated January 31, 2025." I have read, or have had explained to me, the information in the "Vaccine Information Statement(s)". My questions have been answered satisfactorily, and I ask that the flu vaccine be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below.

The Doniphan County Health Department/Home Health Agency ***can bill my insurance for any services rendered as applicable.*** I understand I ***will be responsible for any services provided which my insurance does not cover.*** ALL INFORMATION IS CONFIDENTIAL. I certify that the above information is correct to the best of my knowledge**.** I authorize the release of immunization records for the patient listed above to any licensed physician, primary care provider, local health department, educational institution, or regulated child/adult care facility. I understand any other health information for the patient listed above will not be released without written authorization from the patient's responsible party.

_____ _____

Signature of Patient or Parent/Guardian **Date**

PROVIDER INFORMATION					
Vaccine Provider: Doniphan Co. Health Dept./Home Health Agency			Clinic Site: DPCOHD		
Street Address: 201. S. Main -PO Box 609, Troy	State KS	Zip Code 66087	Street Address: 201 S. Main Street, Troy	State KS	Zip Code 66087

(Circle the appropriate vaccine, dose, extremity, site, route, and write in the manufacturer, lot #, and expiration date)

FOR CLINICAL USE ONLY								
Vaccine	**Dose**	**Ext.**	**Site**	**Route**	**VIS Date**		**Lot # and Exp Date**	
High Dose Tri	**0.5cc** **1**	**RT** **LT**	Deltoid	IM	1/31/25			
FluBlok Tri	**0.5cc** **1**	**RT** **LT**	Deltoid	I M	1/31/25			
Fluzone Tri	**0.5cc** **1 2**	**RT** **LT**	Deltoid Vastus Lat	IM	1/31/25			
Fluzone Tri VFC	**0.5cc** **1 2**	**RT** **LT**	Deltoid	IM	1/31/25			
Fluzone Tri 317	**0.5cc** **1**	**RT** **LT**	Deltoid Vastus Lat	IM	1/31/25			
Flu Mist	**0.2cc**	**Each** **Nostril**	Nasal	Nasal	1/31/25			

Signature and Title of Vaccine Administrator **Date**