VACCINE ADMINISTRATION CONSENT FORM
ALACHUA COUNTY HEALTH DEPARTMENT

NAME_____
LAST **FIRST** **MI**

YOUR AGE TODAY_____ **DATE OF BIRTH**_____ **Insurance Provider**_____ **Policy #** _____

RACE_____ **SEX**_____ **COUNTY OF RESIDENCE**_____ **TELEPHONE (**_____**)**_____

MAILING ADDRESS_____

CITY_____ **STATE**_____ **ZIP** _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

DO YOU HAVE ANY ALLERGIES? _____

	Yes	No	Unsure
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist®) in the past?	☐	☐	☐
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	☐	☐	☐
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders?	☐	☐	☐
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?	☐	☐	☐
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?	☐	☐	☐
8. Is the person to be vaccinated receiving antiviral medications?	☐	☐	☐
9. Is the person to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	☐	☐	☐
10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	☐	☐	☐
11. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐
12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in a protective environment (such as in a hospital room with reverse air flow)?	☐	☐	☐
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐	☐	☐

"I have read or have had explained to me the information about influenza/pneumonia and influenza/pneumonia vaccine(s). I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza/pneumonia vaccine(s) and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request."

I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician or organization furnishing services or authorize such physicians or organization to submit a claim to Medicare for payment for me. I understand if I am a member of an HMO or Medicare is not my primary insurance; I will be personally responsible for any charges not covered by Medicare assignment. By my signature below, I acknowledge receipt of the Notice of Privacy Practices form and the Vaccine Information Statement.

Signature of Recipient/Guardian:_____ Date _____

If someone other than client, print name:_____ Relationship to client _____

*****STAFF USE ONLY *****

DATE VACCINATED:_____ **CLINIC SITE** _____

FLU VACCINE **VIS 08/06/2021**

MFG/LOT #_____ **SITE/ROUTE** ____ **LDT** **RDT** **I M** **I N** ____

NURSE _____