2022-2023 INFLUENZA CONSENT FORM

Information about person to be vaccinated (please print)

First Name: _____ Age: _____

Last Name: _____ Gender: _____

Date of Birth: _____ Phone #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

For child - Parent's Name: _____

____ Insurance	Insurance Company Name: _____
____ Medicaid or Medicare	Policy ID #: _____
____ No Insurance / Insurance that DOES NOT cover vaccines	Policyholder name: _____
____ American Indian or Alaskan Native under 18 (VFC eligible)	Policyholder Birthdate: _____
____ Paid Cash	Relationship: _____

Please answer the following for the person to be vaccinated.

	Yes	No
1) Is the person sick today?	____	____
2) Does the person have an allergy to eggs or to a component of the vaccine?	____	____
3) Has the person ever had a serious reaction to influenza vaccine in the past?	____	____
4) Has the person ever had Guillain-Barre syndrome?	____	____

I have been provided a copy of and have read or have had explained to me the information about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I am responsible for any financial charges not covered by my insurance. A record of this immunization will be entered into the Iowa Immunization Registry System (IRIS).

Signature _____ **Date** _____

Person to be vaccinated (If a minor, parent or guardian)

For office use only

Date: _____

Administered by: _____

IM Site:

Left Deltoid

Right Thigh

VIS 8/6/2021

Billing: ____ **IRIS Entry:** ____ **Location:** _____ **Rev. 9/2022**