SEASONAL INFLUENZA VACCINATION
CONSENT 2023-2024
DEWITT- PIATT BI-COUNTY HEALTH DEPARTMENT

PLEASE PRINT CLEARLY!

NAME:_____**BIRTH DATE:**_____**AGE**_____
(Person receiving vaccination – Name must match Medicare, Insurance or Medicaid Card)

MAILING ADDRESS:_____

CITY/STATE/ZIP:_____

PHONE:_____**GENDER: MALE FEMALE (circle one)**

_____

MEDICARE B or MEDICAID#_____

MANAGED CARE ORGANIZATION: _____**ID NUMBER:** _____

STATE OF ILLINOIS INSURANCE ONLY: Employee _____ Retiree _____ University Staff_____

SOCIAL SECURITY NUMBER - Last 4 digits only for state employees: _____
Please show your cards to staff for confirmation or copies.

DO NOT WRITE BELOW THIS LINE_____FOR NURSES USE ONLY

COMMENTS/VACCINE DEFFERAL: _____

_____

ROUTE/SITE:

SITE: R. DELTOID/THIGH_____**L. DELTOID/THIGH**_____

ADMINISTERED BY: _____**DATE:** _____

VIS GIVEN: Inactivated influenza -08/06/2021

Lot # _____**Manufacturer**_____**Exp. Date**_____

Circle correct CPT CODE – 90686 (VFC/317) 90674 (Flucelvax-PP) 90694 (65+)

Is the client currently sick or have a fever?	**Yes ____No___**
Did the client receive a flu vaccination last year?	**Yes ___ No ___**
Has client ever had an allergic (anaphylactic) reaction to a flu vaccine?	**Yes ___ No ___**
Is the client allergic to eggs or egg products, thimerosal or mercury containing products (such as contact lens solution) or gelatin?	**Yes___ No___**
Does client have a history of Guillain Barre syndrome	**Yes___ No___**
Is the person to be vaccinated younger than age 2 years or older than 49 years?	**Yes___ No___**
Does the client have cancer, leukemia, HIV/AIDS or other immune system problems?	**Yes__ No____**
Does the client have a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (diabetes), neuromuscular disease, or a blood disorder? Is he/she on long term aspirin therapy?	**Yes___ No___**
In the past 3 months has the client taken Prednisone, other steroids, drugs for rheumatoid arthritis, Crohn's disease, or psoriasis, or anti-cancer drugs, anti-viral meds, or radiation treatments?	**Yes___ No___**
Is the client pregnant or could become pregnant in the next month?	**Yes___ No___**
Has the client received vaccinations in the past 4 weeks?	**Yes___ No___**
If the client to be vaccinated is 2 to 4 years of age, has a healthcare provider told you the child has wheezing or asthma in the past 12 months?	**Yes___ No___**
Does the client 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 protective isolation (an isolation room of a bone marrow transplant unit)?	**Yes__ No___**

I have read the information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. I authorize billing of this vaccination to my health insurance. I acknowledge I have received, or requested, a copy of the DeWitt-Piatt Bi-County Health Department Notice of Privacy Practices.

X_____ **X**_____

AUTHORIZING SIGNATURE ***DATE***