INFLUENZA (IIV/RIV) VACCINE CONSENT FORM AND ADMINISTRATION RECORD 2020-2021

WyVIP/VFC Eligibility: Medicaid Uninsured Underinsured Insured Native/Alaskan American WY Resident Non-Resident

Information about person to receive vaccine (please print)

Name: _____ Birth date and age: _____ Sex: Male Female

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Doctor: _____

1. Have you received flu vaccine before?..... ____No ____Yes
2. Did you have any problems with previous flu vaccine?..... ____No ____Yes
3. Are you ill today?..... ____No ____Yes
4. Do you have allergies to eggs, latex, or to Thimerosal Mercury (a preservative)?..... ____No ____Yes
5. Do you have a history of Guillian-Barre Syndrome (a paralysis problem)?..... ____No ____Yes
6. If you are younger than 9 years of age, have you received flu vaccine before?..... ____No ____Yes
7. Have you received a pneumonia vaccine? ____ No ____ Yes If Yes, what year? PPSV23_____ PCV13_____

PAYMENT INFORMATION:

Medicare#_____ Medicaid#_____

Other Pay Source: _____ **PAID BY: CASH_____ CHECK #_____**

Insurance Information	
Primary Carrier Insurance Company	Secondary Carrier Insurance Company
Insurance Carrier Mailing Address City State/Zip	Insurance Carrier Mailing Address City State/Zip
Policy Holder's Name Employer of Policy Holder	Policy Holder's Name Employer of Policy Holder
Policy Holder DOB: Policy Holder's Sex:	Policy Holder DOB: Policy Holder's Sex:
Policy # Group #	Policy # Group #

I have read, or have had explained to me, the Vaccine Information Statement (VIS) about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian). If qualified, I authorize billing to my insurance company or my employer. I have received and read the Wyoming Department of Health Notice of Privacy Practices and have had a chance to ask questions about how my information will be used.

I HAVE BEEN ADVISED TO PROCEED TO THE DESIGNATED PARKING AREA AFTER RECEIVING MY FLU SHOT AND WAIT FOR 15 MINUTES OF OBSERVATION BEFORE LEAVING.

Print Parent/Guardian name, if different from client: _____

Client/Parent/Guardian Signature: _____ Date: _____

FOR CLINIC USE ONLY

CLINIC SITE: _____ VIS DATE: AUGUST 15, 2019

DATE VACCINE ADMINISTERED: _____ DATE BOOSTER REQUIRED: _____

VACCINE MAN. & LOT NUMBER: _____ IIV3 IIV4 HD-IIV4 RIV4 ccIIV4 aIIV4

SITE OF IM INJECTION: RDT OR LDT OR _____ DOSE: 0.5ML 0.25ML
SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR: _____

NURSE'S COMMENTS: _____ SCREENED FOR COVID-19 ☐