Fergus County Nurses Office

Adult Influenza Vaccine Consent

Client's Name:_____/_____/_____ ☐ **Male** ☐ **Female**
First **M.I.** **Last**

Date of Birth:_____/_____/_____ **Age**_____ **Phone**_____

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

Client's Dr.:_____ **Pay Source:** ☐ **Insurance** ☐ **None/Private Pay**

Primary Source of Insurance: (please check one) ☐ **Private Insurance** ☐ **Medicare** ☐ **Medicaid** ☐ **Other**

Insurance Company Name: _____

Insurance Subscriber's Name: **Subscriber's Birth Date:**

Relationship to Subscriber:
Self ☐ **Spouse** ☐ **Child** ☐ **Other** ☐

Subscribers S.S#:

Policy Number:_____

Group Number:_____

Are you sick today?	YES / NO
Are you allergic to meds, foods and/or vaccine component?	YES / NO
Have you had a serious reaction after receiving any vaccine?	YES / NO
Do you have a chronic illness or disease?	YES / NO
Have you ever had Guillain-Barre´Syndrome?	YES / NO

I have read the Vaccine Information Sheet(s) and have had a chance to ask questions. The risks and benefits have been explained to me or the person named for who I am authorized to make this request. I give the consent without coercion or reservation.
I authorized my health care provider and a public health agency to collect and enter my immunization record into the Department of Public Health and Human Services' Immunization Information System (IIS) or imMTrax. The IIS is a confidential, computer system than contains Immunization records. I understand that information in the registry may be released to a public health agency as well as my health care providers to assist in my medical care and treatment. I understand that I can revoke this authorization and have my record removed at any time by contacting my local health department. The above information is true to the best of my knowledge. I authorize Fergus County Nurse's Office to bill my insurance and agree benefits be paid directly to the (Fergus County Nurse's Office). I understand that I am financially responsible for any balance. I also authorize (Fergus County Nurse's Office) or my Insurance Company to release any information required to process my claim(s). I also give permission to the (Fergus County Nurse's Office) to release health care information regarding any vaccinations or reactions to the Health Care Provider I have specified.

X_____ Date:_____
Client Signature or Authorized Representative

For office use only.

Date of service(s) _____

_____**Flu** Priv---Adult State VIS Form: 08/07/2015
Site: RA LA

Lot:_____ Exp. Date: _____

_____
RN Signature

PCV13 or PPV23

____**Pneumonia** Priv---Adult State VIS Form: 11/5/2015/ 4/24/2015
Site: RA LA

Lot: _____ Exp. Date: _____

_____
RN Signature

Request a check on last pneumonia date: _____