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 Doctor.:________________________________**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 a component of the vaccine?	YES / NO
Have you had a serious reaction to influenza vaccine in the past?	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 that 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) ______________________________ PCV13 VIS Form: 08/06/21 or PPV23 VIS Form: 10/30/19

________**Flu** **Priv---Adult State** VIS Form: 08/06/21
Site: RA LA

Lot:_________________ **Exp. Date:** ___________

____
RN Signature

_____**Pneumonia** **Priv---Adult State**
Site: RA LA

Lot: __________________ **Exp. Date:** ___________

____
RN Signature

Request a check on last pneumonia date: ______