Influenza Immunization Questionnaire / Consent Form

Patient Name: _____ Gender ☐ F ☐ M Phone (_____)_____

Mailing Address _____Unit/Apt#: ____ City/State/Zip Code _____

Birth Date ____ Month/____ Day/____Year Age Today _____ History of Chicken Pox: ☐ Yes (☐Verbal report; ☐MD/lab confirmed) ☐No

Race (Check one box only)	**Ethnicity** (Check one box only)	**Patient's Social Security #**
☐ Caucasian ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native ☐ Pacific Islander	☐ Hispanic/Latino ☐ Not Hispanic/Latino	_____ - _____ - _____ Required to access your immunization records online

Insurance Status (Check one box only) **** Please include a copy of the front and back of insurance card***

☐ **Insured:** **Insurance Company:**_____ **Insurance/ID #:**_____
Group #:_____ **Policy Holder Name:**_____ **Birth Date:** ____/____/_____

☐ **Medicaid / NV Check Up #:**	☐ **Medicare #:**	**Policy Holder Relationship to Patient:** _____

☐ **Uninsured / No insurance** * Please include $20 for administration fee or whatever you can afford	☐ Insured, but vaccines are not a covered benefit * Please include $20 for administration fee or whatever you can afford

Please answer the following questions about THE PERSON to be vaccinated

1. Been vaccinated against influenza (flu) in the past?	☐ YES	☐ NO
2. Sick today?	☐ YES	☐ NO
3. Allergic to eggs, latex, food, medication, vaccine ingredients? If yes, list:	☐ YES	☐ NO
4. Had a serious reaction to or fainted with previous immunization?	☐ YES	☐ NO
5. Had Guillain-Barre syndrome in the past?	☐ YES	☐ NO
6. Had seizure or other nervous system problem?	☐ YES	☐ NO
7. Have cancer, AIDS or other immune system problems?	☐ YES	☐ NO
8. Taken cortisone, prednisone or any steroids, anti-cancer drugs, or radiation in the last 3 months?	☐ YES	☐ NO
9. Received antiviral drugs in the last 3 months	☐ YES	☐ NO
10. Received any other immunizations, including influenza, in the last month? If yes, list:	☐ YES	☐ NO
11. Received a blood or blood product transfusion, or been given immune (gamma) globulin in the last year?	☐ YES	☐ NO
12. Have long-term medical problems: diabetes, heart, kidney or lung disease, asthma, wheezing or blood disorders?	☐ YES	☐ NO
13. Pregnant or plan to become pregnant in the next month?	☐ YES	☐ NO

I have received and understand the vaccine information sheet(s) for the immunization(s) to be administered. I authorize CCHHS to enter this information into the Nevada Immunization Registry, unless otherwise specified. I understand the CCHHS Notice of Privacy is available at gethealthycarsoncity.org/immunizations. I hereby authorize & direct payment of medical benefits to CCHHS for any services provided to me or my dependents.

If my carrier deems these services non-payable, I agree that I am financially responsible for any outstanding balances.

Client/Parent/Guardian **Signature** _____ Date _____/_____/_____
Parent/Guardian signature required if under 18 years old

Client/Parent/Guardian **Print Name** _____ Email: _____

CLINIC USE ONLY – DO NOT WRITE BELOW THIS LINE					Circle Location Below		
					RD	LD	IM

Administered by: _____ **Date:** ____/_____/_____ **Clinic Location:** _____
(Write Legibly) First Initial Last Name Credential

Amount $: _____ ☐ Cash ☐ Check	**$ Reconciliation:**	**Trans RX:**	**eCW/Scan:**	**eCW Charting:**