Seasonal Influenza Consent Form (English)

Complete the following for the person who is being vaccinated:

Patient Name: First_____ **Middle**_____ **Last**_____
Phone: (_____**)**_____ **Birth Date:** _____**Month/**_____ **Day/**_____**Year Age Today:** _____ **Sex:** ☐ **F** ☐ **M** ☐ **Other**
Mailing Address: _____ **City/State/Zip Code:** _____

Parent/Guardian Full Name: _____ **Mothers Maiden Name:** _____

Insurance Status (Check one box only) **** Insurance/Medicaid # is required if you are insured!***

☐ **Insured: Insurance Company:**_____ **Claim Address:**_____

Policy/Member ID #: _____ **Group # (if one applies):** _____

Policy Holder Name: _____ **Policy Holder Relationship to Patient:** _____

Policy Holder Birth Date: _____/_____/_____ **Social Security Number:** _____-_____-_____

***If this section is incomplete, you may be billed for full cost of vaccine and administration fee.**

☐ **Medicaid / NV Check Up #:**	☐ **Uninsured (*If possible, attach $20 payment)**

Questions for the person getting vaccinated today:

1. Is the person to be vaccinated sick today? If yes, what are their symptoms?	☐ **YES**	☐ **NO**
2. Has the person been vaccinated against influenza (flu) in the past?	☐ **YES**	☐ **NO**
3. Does the person have any allergies, such as eggs, a vaccine component or latex? If yes, list what allergies:	☐ **YES**	☐ **NO**
4. Has the person ever had a serious reaction to a vaccine in the past? If yes, please explain:	☐ **YES**	☐ **NO**
5. Has the person ever had Guillain-Barre Syndrome in the past?	☐ **YES**	☐ **NO**

READ AND SIGN:

- I have received and understand the vaccine information statement(s) and I have had the opportunity to ask questions for the immunization(s) to be administered to me or the person named above, for whom I am authorized to make this request.
- I agree to allow my immunization information, or the person named above, for whom I am authorized to make this request, to be stored and accessed by authorized users in "Nevada's WebIZ" computer system unless I indicate otherwise.
- In the event of needlestick injury or exposure to blood or bodily fluids, I also agree to have my blood tested for bloodborne bacteria or viruses that my result in disease, or the person named above, for whom I am authorized to make this request.

By signing this document, I declare that the above information is true and accurate to the best of my knowledge. I authorize Carson City Health and Human Services (CCHHS) to bill my insurance carrier for services received by myself or my dependents. I authorize insurance reimbursement to be paid directly to CCHHS. I am responsible for any outstanding balance on my account or account(s) of my dependent(s). I authorize the release of any medical or other information necessary to process insurance claims and I agree to allow my medical records to be shared within CCHHS programs.

To view the Notice of Privacy Practices form, please scan the QR code or visit our website:

https://www.gethealthycarsoncity.org/CommunityFlu

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

CCHHS is required to ask the following questions according to federal and/or state law: NRS.449.104 effective January 1, 2020

Race (Check all that apply) ☐ **Choose not to disclose**
☐ **White** ☐ **Black/African American** ☐ **Pacific Islander** ☐ **American Indian/Alaskan Native** ☐ **Asian** ☐ **Other**

Ethnicity (Check one box) ☐ **Choose not to disclose**
☐ **Hispanic/Latino** ☐ **Not Hispanic/Latino**

Birth Sex (Check one box) ☐ **Choose not to disclose**
☐ **Female** ☐ **Male** ☐ **Other**

Gender Identity (Check one box) ☐ **Choose not to disclose**
☐ **Female** ☐ **Male** ☐ **Genderqueer**
☐ **Female-to-male/Transgender male/Trans man**
☐ **Male-to-female/Transgender female/Trans woman**
☐ **Additional gender category or other, please describe:**
_____

Preferred Pronouns (Check one box) ☐ **Choose not to disclose**
☐ **She/her/hers**
☐ **He/him/his**
☐ **They/them/theirs**
☐ **Additional pronoun category or other, please describe:**
_____

Sexual Orientation (Check one box): ☐ **Choose not to disclose**
☐ **Straight or heterosexual** ☐ **Bisexual** ☐ **Gay, Lesbian, or homosexual** ☐ **Other** ☐ **Do not know**

CLINIC USE ONLY – DO NOT WRITE BELOW THIS LINE

Administered by: _____ Credential:_____ Date: ___/___/____ **RD** ☐ **LD** ☐ **OTHER** ☐
Amount $: _____ Received by: _____ Cash ☐ Check ☐ Check #: _____
$ Reconciliation by and Date: _____ Scan by and Date: _____ Charted by and Date: _____