Knox Public Health

Flu Vaccine Consent

2020-2021

KNOX COUNTY COMMUNITY Health Center

Patient Information (Please Print)			
Last Name: **First Name:** **MI:**		**Date of Birth/Age:**	**Phone #:**
Home Address:			**SS#**
City:	**State:**	**Zip:**	**County:**
Gender:	**Race:**	**Ethnicity:** Hispanic/Latino **or** Not Hispanic/Latino	
Do you live within Mount Vernon city limits? **Yes** ☐ **No** ☐			
Insurance Information			
Medicare Plan/Number:		**Medicaid Plan/Number:**	
Private Insurance Company Name:			
Member ID#		**Group #**	
Insured Name/DOB:		**Relationship to Insured:**	

Please answer the following questions		
1. Are you sick today?	Yes ☐	No ☐
2. Allergic to eggs? (Can't eat eggs)	Yes ☐	No ☐
3. Ever had a serious reaction after receiving a vaccination?	Yes ☐	No ☐
4. Ever had a paralyzing illness (Guillain Barre Syndrome) after a flu vaccination?	Yes ☐	No ☐
5. Have you received the flu vaccine before?	Yes ☐	No ☐
6. Female Only: Are you currently pregnant?	Yes ☐	No ☐
7. For children under 9 years of age: has the child received 2 flu vaccines?	Yes ☐	No ☐
8. Taking medication that lowers the body's resistance to infection?	Yes ☐	No ☐

Knox Public Health (KPH) or the Health Center may keep this record in your medical file. They will record what vaccine was given, date the vaccine was given, the name of the company that made the vaccine, the vaccine special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. I understand that this information will be released to a state-wide Immunization Registry for the purpose of immunization tracking recall and recording, unless I request otherwise. I have read or have had explained to me the Vaccine Information Sheet about influenza disease and the influenza vaccine. I have had a chance to ask question, and they were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to the person named above for whom I am authorized to make this request. Your medical information is never shared without an authorization to release information. A copy Knox Public Health's Notice of Privacy Practices (HIPAA) will be provided upon request, and it is also located on our website at www.knoxhealth.com. I authorize my insurance company to assign the amount payable directly to KPH. I understand that I am financially responsible for all the charges that are not covered under my private insurance plan. I acknowledge that any co-payment is due and payable on the date services are received.

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY

INFLUENZA	**INJECTION SITE**	**VACCINE MANUFACTURER**	**NURSE SIGNATURE**
PRIVATE VFC 317 E-clinical ___ ImpactSIIS ___	RD LD IM LVL RVL PRES. FREE W/ PRES.	GSK SP LOT #_____ Quadrivalent EXP:_____	Date:_____ _____, RN

Created By: LD 9/9/20