Influenza Form

NAME: _____ **DATE OF BIRTH**: _____ **AGE:**_____

STREET ADDRESS: _____ **SEX:** ☐ Male ☐ Female

CITY:_____ **STATE:** _____ **ZIP:** _____ **PHONE:** _____

Print name exactly as it appears on insurance card: _____

Name of Insurance Company: _____

Insurance Number: _____

Name of Insured: _____ **Insured's Date of Birth:** _____

Policyholder's Name AND Date of Birth (if different from patient): _____

I have been given a copy of the **Vaccine Information Statement**..... ☐ **YES** ☐ **NO**

I have been offered a copy of the **Notice of Privacy Practices** with the effective date of September 23, 2013. ..... ☐ **YES** ☐ **NO**

I understand that this vaccination will be included in the **Kansas Immunization Registry**.

1. Is the person to be vaccinated sick today? ☐ **YES** ☐ **NO** ☐ **Don't know**
2. Does the person to be vaccinated have an allergy to eggs or to a component of the eggs? ☐ **YES** ☐ **NO** ☐ **Don't know**
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? ☐ **YES** ☐ **NO** ☐ **Don't know**
4. Has the person to be vaccinated ever had Guillain-Barrè syndrome? ☐ **YES** ☐ **NO** ☐ **Don't know**
5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot? ☐ **YES** ☐ **NO** ☐ **Don't know**

I understand the benefits and risks of the Influenza (FLU) vaccine and ask the vaccine be given to me or to the person named for whom I am authorized to make this request. Further, I authorize the release of any medical information necessary to process my insurance claim(s) or as needed by my insurance carrier. I authorize and request payment of medical benefits directly to my medical provider. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I am responsible for payment for all services rendered to me or my dependent including any remainder not covered by insurance.

_____ _____

Signature of Patient or Patient Representative **Date**

FOR OFFICE USE ONLY

Clinic Site: _____ Date of Injection: _____ Injection Site: _____

Manufacturer: _____ Lot #: _____ Exp Date: _____

Signature of Nurse: _____