Franklin County Health Department
1418 S. Main St., Ste. #1 | Ottawa, KS 66067
(785) 229-3530

Name: _____Date of Birth: _____Age:_____

Address: _____Sex: Male ☐ Female ☐

City: _____ State: _____Zip:_____Phone: _____

Print patient name exactly as it appears on insurance card: _____

Insurance Company: _____Insurance #: _____

Name of Insured_____Insured's DOB: _____

Relationship to the Insured_____

*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 consent to have this immunization be put in the Kansas Immunization Registry:

Yes _____ No _____

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 ☐Yes ☐No ☐Don't know to a component of the eggs?
3. Has the person to be vaccinated ever had a serious reaction ☐Yes ☐No ☐Don't know to influenza vaccine in the past?

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 _____