Lakes Regional Healthcare
An Avera Partner

DICKINSON COUNTY PUBLIC HEALTH
2301 HWY 71 S • P. O. Box AB
Spirit Lake, IA 51360
Phone: (712) 339-6050 Fax: (712) 339-6052

Public Health
Prevent. Promote. Protect.

FLU CONSENT

Today's Date _____

SCREENING QUESTIONS - Please circle Y or N for Yes or No.

	Family Member #1	Family Member #2	Family Member #3	Family Member #4	Family Member #5	Family Member #6
(Please Print) First AND Last Name						
Date of Birth						
Age						
Primary Physician/Nurse Practitioner						
First time receiving the flu vaccine? *It is recommended that children 8 and under who have NEVER had flu vaccine or had only one dose, receive two dose in the same flu season.	Y N	Y N	Y N	Y N	Y N	Y N
Allergies to chicken eggs, egg products, thimerosal, latex or any component of the flu vaccine?	Y N	Y N	Y N	Y N	Y N	Y N
Have you/your child ever had a **severe** allergic reaction to previous flu vaccine?	Y N	Y N	Y N	Y N	Y N	Y N
Do you have a history of Guillain-Barre Syndrome (GBS)?	Y N	Y N	Y N	Y N	Y N	Y N
Have you received any vaccines in the past 30 days? If yes, list vaccines and dates in the box.	Y N	Y N	Y N	Y N	Y N	Y N

Address: _____ **P. O. Box:** _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone: _____ - _____ - _____ **Alternate Phone (Optional):** _____ - _____ - _____

Please Present Health Insurance Card / MEDICARE PART B Card / Medicaid - T-19 Card (Iowa Total Care /Amerigroup)

FINANCIAL RESPONSIBILITY

FINANCIAL RESPONSIBILITY - All or part of the amount charged will be billed to my insurance carrier(s). Any amount the insurance companies pay will be applied to the amount due and any amount my carrier deems payable by the insured will be billed to me. I understand I will have 30 days from the date of the statement to send payment to the clinic. I understand that I am ultimately responsible for payment of the immunizations and/or the administration fees charged. All information provided is true and correct to the best of my knowledge. **For Children 18 Years old and younger- If your insurance does not cover immunizations, vaccine will be provided through the Vaccine for Children (VFC) Program. A donation of $15 to cover the cost of the administration would be appreciated.**

Turn page over to complete

CONSENT

CONSENT - I have read or had explained to me the information in the Vaccine Information Statement about the 2019-2020 influenza vaccine **(08/15/2019)**. I believe I understand the benefits and the risks of the influenza vaccine and ask that the vaccine be given to me and/or my child/children. I understand that these vaccines will be entered into the Iowa Immunization Registry (IRIS). I attest I am the child's/children's parent/legal guardian and may provide consent for the immunizations. My signature below indicates my consent for me and/or my child/children to receive these vaccines.

Patient/Guardian/DPOA Signature _____ **Spouse Signature (If listed as a patient)** _____

For Office Use Only *** (Age 8 and under if required) * 2nd Dose required if child is 8 or younger and has NEVER had flu vaccine or has only had 1 dose of flu vaccine.**

	Family Member Name	Nurse Initials	Dose & Route	Site		QUAD P-FREE Dose 1	Quad P-FREE Dose 2*	Fluzone HIGH DOSE
1.			.5 ml IM	RD / RT	LD / LT			
Child Medicaid	**No Health Insurance**	**AI/AN**	**UI**	**Not Eligible for VFC**	**Adult Medicaid**	**Medicare Part B**	**Medicare Advantage**	**Private Pay**	**Bill to Other**	**Staff Initials**
2.			.5 ml IM	RD / RT	LD / LT			
Child Medicaid	**No Health Insurance**	**AI/AN**	**UI**	**Not Eligible for VFC**	**Adult Medicaid**	**Medicare Part B**	**Medicare Advantage**	**Private Pay**	**Bill to Other**	**Staff Initials**
3.			.5 ml IM	RD / RT	LD / LT			
Child Medicaid	**No Health Insurance**	**AI/AN**	**UI**	**Not Eligible for VFC**	**Adult Medicaid**	**Medicare Part B**	**Medicare Advantage**	**Private Pay**	**Bill to Other**	**Staff Initials**
4.			.5 ml IM	RD / RT	LD / LT			
Child Medicaid	**No Health Insurance**	**AI/AN**	**UI**	**Not Eligible for VFC**	**Adult Medicaid**	**Medicare Part B**	**Medicare Advantage**	**Private Pay**	**Bill to Other**	**Staff Initials**
5.			.5 ml IM	RD / RT	LD / LT			
Child Medicaid	**No Health Insurance**	**AI/AN**	**UI**	**Not Eligible for VFC**	**Adult Medicaid**	**Medicare Part B**	**Medicare Advantage**	**Private Pay**	**Bill to Other**	**Staff Initials**
6.			.5 ml IM	RD / RT	LD / LT			
Child Medicaid	**No Health Insurance**	**AI/AN**	**UI**	**Not Eligible for VFC**	**Adult Medicaid**	**Medicare Part B**	**Medicare Advantage**	**Private Pay**	**Bill to Other**	**Staff Initials**