Delaware General Health District
Flu Vaccine Consent Form

PLEASE PRINT CLEARLY

First Name: | | | | | | | | | | | | | | | | | | | | | | Middle Initial: | |

Last Name:

Address:

City: State: Zip:

Phone: ___ - ___ - ___ Birthdate: M M / D D / Y Y Y Y Gender:

Home Cell Work (please circle one)

OPTIONAL DEMOGRAPHICS (please circle)

Race: White/Caucasian Black/African American Native Hawaiian Alaska Native Asian American Indian Other

Ethnicity: Hispanic/Latino NOT Hispanic/Latino Other Preferred Language:____________________

Primary Insurance Company: ____________________ **Name of Primary Insured:**____________________

Member ID:____________________**GROUP#**____________________

Primary Insured Birthdate:____________________ **Relationship to Primary Insured:**____________________

Address of Primary Insured (if different from patient):____________________

Secondary Insurance Company: ____________________ Name of Primary Insured:____________________

Member ID:____________________GROUP#____________________

Primary Insured Birthdate:____________________ Relationship to Primary Insured:____________________

Address of Primary Insured (if different from patient):____________________

IF NO INSURANCE, PLEASE COMPLETE THE FOLLOWING TO REQUEST DISCOUNTED SERVICES:

"I state that there are ________ number of people living in my household
and the combined household income is $____________ per week / month / year" (circle one)

Please answer the following questions:	
1. Are you sick today?	Yes___ No___
2. Are you allergic to eggs? (Can't eat eggs)	Yes___ No___
3. Are you allergic to any vaccine components? If yes, what component? ____________________	Yes___ No___
4. Have you ever had a serious reaction after receiving a vaccination?	Yes___ No___
5. Have you ever had a paralyzing illness (Guillain Barre Syndrome)?	Yes___ No___
6. For children under 8 years of age, since 2010, has your child received 2 flu vaccines?	Yes___ No___
7. Do you have AIDS, HIV, Cancer, or have you received an organ transplant, or taking medication that lowers the body's resistance to infection?	Yes___ No___

The doctor or clinic 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 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 of the Health Districts Notice of Privacy Practices (HIPAA) will be provided upon request, and it is also located on our website at www.delawarehealth.org. I authorize my insurance company to assign the amount payable directly to DGHD. 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 Name (please print clearly):____________________Date:__________

Relationship to patient:____________________ Parent/Guardian DOB:__________

Patient/Guardian Signature:____________________

STOP — AREA BELOW FOR OFFICE USE ONLY

INFLUENZA	INJECTION SITE	VACCINE MANUFACTURER	NURSE SIGNATURE
PRIVATE VFC ☐ NN ☐ IMPACT	RD LD IM INTRANASAL PRES. FREE W/ PRES.	GSK SP MED LOT #________________________ Quadrivalent EXP: 6/30/17 EXP:___________	Date:________________________ _________________________, RN

NOTES:____

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