Thomas County Health Department

2016 -17Influenza Consent Form
This voucher permits the individual named below to receive influenza vaccine
BRING THIS VOUCHER WITH YOU

Cash / Credit / Check #
Contract Pay:
Inavirona

	Dispense Assist	Contract Pay:
Demographic Information		Insurance:
First Name:	Vaccine: <u>Seasonal Influenza</u>	
Last Name:		
Last Name:	First Name: T	
Address:	Last Name:	OOB:
Address2: Sex: City, St Zip: Health History Information (Please Circle Answer) 1. Has this person had a serious reaction to vaccine in the past? Yes No 2. Is this person allergic to eggs or egg products? Yes No 3. Does this person have a history of Gullain-Barre syndrome? Yes No 4. Is this person allergic to Thimerosal or mercury? Yes No 5. Does this person have a history of Asthma? Yes No 6. Is this person Immunocompromised? Yes No 7. Has this person had a live vaccine the past four weeks? Yes No 8. Is this person pregnant? Yes No 9. Does this person live with someone with weaken immune system? Yes No 1, the undersigned, certify that all of the above information is correct to the best of my knowledge. I hereby authorize the recipient of this document to share this information with public health entities at the local, state and federal level for purposes of ensuring medication efficacy and safety. I have been offered a copy of Notice of Information Practices. Clinician Use Only: Vaccine Provided: Immarkasal Place Lot # Sticker Here Location: (R) (L) (Deltoid) (VL) Clinic Site:	Address: A	Age:
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Place Lot # Sticker Here Location: (R) (L) (Deltoid) (VL) Clinic Site:	Clinician Use Only:	
Clinic Site:	Vaccine Provided: IM Nasal	
	Place Lot # Sticker Here Location: (R) (L) (Delto	oid) (VL)
Vaccinator's Signature: Date:	Clinic Site:	
	Vaccinator's Signature: Date	3)

Fact sheet: Vaccine Information Statement

Notice of Information Practices