Thomas County Health Department
2016 -17Influenza Consent Form

This voucher permits the individual named below to receive influenza vaccine

BRING THIS VOUCHER WITH YOU

Dispense Assist
Seasonal Influenza Vaccine Voucher

Cash / Credit / Check # _____

Contract Pay: _____

Insurance: _____

Vaccine: Seasonal Influenza

Demographic Information

First Name: _____
Last Name: _____
Address: _____
Address2: _____
City, St Zip: _____

Telephone: _____
DOB: _____
Age: _____
Sex: _____

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

I, 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.

Client Signature: _____ Date Signed: _____

Clinician Use Only:

Vaccine Provided: ☐ IM ☐ Nasal

Place Lot # Sticker Here

Location: (R) (L) (Deltoid) (VL)

Clinic Site: _____

Vaccinator's Signature: _____ Date: _____

Fact sheet: ***Vaccine Information Statement***
Notice of Information Practices