

Thomas County Health Department

2016 -17 Influenza 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: _____

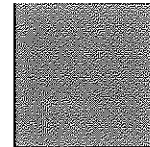
Date Signed: _____

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