Influenza Consent Form

This voucher permits the individual named below to receive influenza vaccine

BRING THIS VOUCHER WITH YOU

STAFF USE ONLY
Cash/Credit/Check # ____________
Contract Pay: __________________
Insurance: ______________________
KanCare Title 19: ☐ Title 21: ☐

Vaccine: <u>Seasonal Influenza</u>

<u>Demographic Information</u>

Name: ______________________________
Address: ____________________________
City, State, Zip: ______________________
Telephone: __________________________
Date of Birth: ________________________
Age: _____ Sex: M or F

Thomas County Health Department
350 S. Range, Suite #2
Colby, KS 67701
Phone: 785.460.4596 Fax: 785.460.4595
Visit our website at: www.thomascohealth.com
Find us on Facebook: @thomascountyhealthdept

<u>Health History Information</u> (Please check answer)

1. Has this person had a serious reaction to vaccine in the past? Yes No
   1a. Person had cardiac arrest, collapsed or called 911 after getting vaccine? Yes No
2. Does this person have an allergy to eggs or egg products? Yes No
   2a. Has this person had a reaction to eggs involving symptoms other than hives, such as angioedema, respiratory distress, lightheadedness, or recurrent emesis; or who required epinephrine or another emergency medical intervention? Yes No
3. Has this person ever had Guillain-Barre Syndrome (GBS)? Yes No
   3a. Person had a history of GBS within six weeks after having flu vaccination? Yes No
4. Is this Person allergic to Thimerosal or mercury products? Yes No
   4a. Person experienced respiratory distress or collapsed using Thimerosal products? Yes No
5. Is this Person currently having any signs or symptoms of COVID-19? Yes No
   5b. Has this person been advised by a healthcare provider that you are a suspect case of COVID-19, regardless of signs or symptoms? Yes No

I, the undersigned, certify that all 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 Notice of Thomas County Health Department Privacy Practices effective 1/1/2023.

Client Signature: ______________________________________ Date: ______________________

<u>Clinician Use Only:</u>

Vaccine Provided: IM Location: R L Deltoid VL
Clinic Site: _____________________
Vaccinator's Signature: _________________________________ Date: _______________________

<u>Lot Numbers</u>
Private: **9CE79 Exp. 6/30/2024**
VFC:
317:
High Dose: **UT8079AA Exp. 6/30/2024**

<u>Vaccine Information Statements</u>
VIS Date: 08/06/2021

WebIZ: _____ Scanned: _____ Billed: _____