INFLUENZA (IIV/RIV) VACCINE CONSENT FORM AND ADMINISTRATION RECORD 2019-2020

WyVIP/VFC Eligibility (Please Circle what applies:) Medicaid Uninsured Underinsured Insured Native/Alaskan American WY Resident Non-Resident

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)

Name: ____

Birth Date and Age: ____________________ Sex: Male Female

Address: ____

City: ________________________ State: _____ Zip: ______

Phone: ______________ Doctor: ________________________

Email: ____

Age Group	Dosage Schedule
9 Years and older	**0.5ML: One dose**
3-8 Years	**0.5 ML: One dose***
6 Months - 35 Months	**0.25 ML: One dose*†**

** For children younger than 9 years of age, refer to the 2018 ACIP Recommendations to determine the need for one or two doses. If two doses are needed, separate the doses by at least 4 weeks.*

†Dosage for age may vary by brand of vaccine. See package insert.

1. Have you received flu vaccine before? ____No ____Yes
2. Did you have any problems with previous flu vaccine? ____No ____Yes
3. Are you ill today? ____No ____Yes
4. Do you have allergies to eggs, latex or to Thimerosal Mercury (a medication preservative)? ____No ____Yes
5. Do you have a history of Guillian-Barre Syndrome (a paralysis problem)? ____No ____Yes
6. If you are younger than 9 years of age, have you received flu vaccine before? ____No ____Yes
7. If over 65, have you received a pneumonia vaccine? ___ No ___ Yes What year? PPSV23 _____ PCV13_____

I have read, or have had explained to me, the Vaccine Information Statement (VIS) about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian). If qualified, I authorize billing to my insurance company or my employer. I have received and read the Wyoming Department of Health Notice of Privacy Practices and have had a chance to ask questions about how my information will be used.

➡ Print Parent/Guardian name, if different from client: ______________________________________

✖ **Client/Parent/Guardian Signature**: ________________________________ Date: ______________

PAYMENT INFORMATION:

Medicare#_______________________________ Medicaid#_______________________________

Other Pay Source: ________________________________ **PAID BY: CASH______ CHECK #________**

Insurance Information			
Primary Carrier Insurance Company		Employer of Policy Holder	
Insurance Carrier Mailing Address City State/Zip		Policy Holder DOB:	Policy Holder's Sex:
Policy Holder's Name		Policy #	Group #

FOR CLINIC USE ONLY

CLINIC SITE: **UINTA COUNTY PUBLIC HEALTH** VIS DATE: AUGUST 15, 2019

DATE VACCINE ADMINISTERED: ____________________ BOOSTER REQUIRED? NO YES --DATE: ______________

VACCINE MANUFACTURER & LOT NUMBER: ____________________________________

SITE OF IM INJECTION: RDT OR LDT RLT OR LLT DOSE: 0.5ML 0.25ML

SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR: ______________________________________

NURSE'S COMMENTS: ______________________________________ FORM REVIEWED BY:_______