Pottawatomie County Health Department

FLU VACCINE DOCUMENTATION AND CONSENT FORM

X Influenza Vaccine

VACCINE ELGIBITILITY (FOR OFFICE USE ONLY)

☐ KanCare
☐ Private
☐ No Insurance

PATIENT INFORMATION / INSURANCE INFORMATION

First Name: _____

Last Name: _____

Gender:M ☐ **F**☐

Ethnicity: **Hispanic**☐**Non-Hispanic** ☐

Race: **W**☐**African Am.**☐ **Asian** ☐ **NH/PI**☐

DOB: __ __ _____ **Age:**_____

Address: _____

_____

Insurance Policy Holder Name: _____

DOB: Relationship:

As the client or parent/legal guardian, I understand I will be responsible to pay for any immunizations provided that Medicaid, Medicare, KanCare, Cigna, Tricare or any other private health insurance does not cover. Pottawatomie County Health Department is not an in-network provider for Cigna, TriCare, or Aetna. ***Initials:***_____

Date:

IMMUNIZATION SCREENING QUESTIONNAIRE

1. Is the patient to be vaccinated sick today or experiencing a fever? If yes, please explain:	YES ☐	NO ☐
2. Has the patient to be vaccinated ever had a life-threatening reaction to any food, medication, eggs or vaccine? (e.g., anaphylaxis, trouble breathing, hives) If yes, please list:	YES ☐	NO ☐
3. Has the patient to be vaccinated ever had Guillain-Barre syndrome? (Symptoms start as weakness and tingling in the feet and legs that spread to the upper body.)	YES ☐	NO ☐

By signing this form, I give consent to the above vaccine to be administered to me, or to the person named above, for whom I am authorized to make this request. I have been offered a copy of the Vaccine Information Statement (VIS) for the vaccine. I understand and am aware I am advised to wait for 15 minutes post vaccination for monitoring. I acknowledge that I have received a copy of the Pottawatomie County Health Department's Notice of Privacy Practices with the effective date of May, 24,2023. I consent to the inclusion of this immunization data in the Kansas Immunization Registry, Integrated Referral and Intake System (IRIS), and Data Application and Integration Solution for the Early Years (Daisey) system. I consent to the sharing of this immunization data with any licensed physician, our primary care provider, educational institutions and/or health insurance companies that request this information, on behalf of the person named above.

By signing this document electronically, the parties agree that electronic signatures are the legally binding equivalent to handwritten signatures, and that the electronic signatures below constitute acceptance and agreement to the consent of the vaccinations with the same validity and meaning as handwritten signatures. The parties agree that they will not, at a later date, repudiate the meaning of the electronic signature or claim that electronic signatures are not legally binding. The parties further agree that the electronic version of this document bearing the electronic signatures of the parties will be considered "in writing" and "wet-signed" and that a printed copy of this electronically signed document will be deemed an original.

Signature of Patient or Legal Parent/Guardian: **Printed Name of Person Signing:** **Relationship of person signing:**

_____ _____ _____