2022 Flu Vaccine Consent Form – PRINT ONLY – SIGN BACK

Patient First Name ______ Patient Last Name ______ Initial ______ Patient Date of Birth ______ ☐ Male ☐ Female

Parent/Guardian Name (if client is a minor) ______ Date of Birth ______ ☐ Responsible Party

Mailing Address ______ City ______ State ______ Zip Code ______

Phone Number ______

NOTE: Without insurance information you will receive a BILL

- Price: Adult $40, Age 65+ High Dose $95, Children 18yrs and under $20
- Children 18yrs and under will not be denied a flu shot due to inability to pay.
- For Tricare use the benefits number from BACK of card for member ID

DOES PATIENT HAVE NSURANCE

Y **N**

Name of Insurance Company ______ Member ID Number ______

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please see the back side of this page or ask your healthcare provider to explain it.

YES	NO	N/A	
☐	☐	☐	1. Have you ever had a severe reaction after receiving a vaccination (i.e., rash, hives, difficulty breathing)? ***Please list reaction(s):***
☐	☐	☐	2. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (i.e., diabetes), anemia, other blood disorder or a chronic condition you see a provider for? ***Please list your chronic condition(s):***
☐	☐	☐	3. Are you sick today with a fever or diarrhea?
☐	☐	☐	4. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? ***Please list:***
☐	☐	☐	5. In the ***past 3 months***, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? ***Please list medication(s):***
☐	☐	☐	6. Do you have allergies to any of the following? ***Please circle which one(s):*** latex / neomycin / gentamicin / yeast / gelatin / monosodium glutamate / eggs
☐	☐	☐	7. ***For women:*** Are you pregnant or a chance you could become pregnant during the next month?
☐	☐	☐	8. Have you had a seizure, a brain, or other nervous system problem?

****FOR OFFICE USE ONLY****

	Site	Lot #		Site	Lot #
Flu:	______	______	Prev20 / Pneu23:	______	______
Flumist:	______	______	______	______	______
High Dose Flu:	______	______	RN Signature/Date:	______	

South Central Public Health District

Prevent. Promote. Protect. *phd5.idaho.gov*

CLIENTS 18 YEARS AND YOUNGER WILL ONLY RECEIVE FLUMIST

Vaccine information sheets (VIS) can be found at:

https://www.immunize.org/vis/flu_inactive.pdf (Injectable)

https://www.immunize.org/vis/flu_live.pdf (Flumist)

MEDICAL SERVICES CONSENT

Immunization Services

- I have been offered copies (electronic and/or paper) of the Vaccine Information Statements for all vaccines being given today.
- I understand that vaccines are not mandatory and may be refused for religious and/or other grounds.
- I understand the benefits, risks, or complications from vaccines. (Further information about the vaccines being offered is available upon request).
- I understand that all immunization records will be entered into the IRIS (Immunization Reminder Information System). Participation in the immunization registry is voluntary. To have your records removed from IRIS, you must contact the Idaho Immunization Program.
- I have been offered a copy of SCHPD's Notice of Privacy Practices.
- I consent to receive vaccinations provided by SCPHD for myself or for this child for whom I am the parent or legal guardian.

FINANCIAL CONSENT

- SCPHD will bill your insurance company for you and the payment may come directly to SCPHD
- SCPHD may not be considered an In-Network provider and therefore cannot guarantee coverage by your insurance company.
- Whether your insurance company pays or not, your account balance is your responsibility.
- Some, or perhaps all, of the services provided may be non-covered services.
- Confidentiality cannot be guaranteed with insurance billing. Your insurance provider may send information to the holder of the insurance policy (who may be your parent, guardian or spouse).

I have read the Financial and Medical Consent and I understand and agree to these policies. I also understand that I will be responsible for payment of all services. I authorize release of medical information necessary to process medical claims and authorize payment of benefits to SCPHD.

____ ____________________

Signature (If minor, signature of responsible party) Date

TWIN FALLS: (208) 737-5966 HEYBURN: (208) 678-8221 GOODING: (208) 934-4477

JEROME: (208) 324-8838 BELLEVUE: (208) 788-4335