TWO RIVERS PUBLIC HEALTH DEPARMENT INFLUENZA CONSENT FORM

STUDENT/STAFF MEMBER INFORMATION

SCHOOL	GRADE	TEACHER

LAST NAME	FIRST NAME	MI	MAIDEN NAME (IF APPLICABLE)

DATE OF BIRTH	AGE	SEX	MOTHER'S MAIDEN NAME (FIRST AND LAST)	PHONE
__/__/____		M F		( )

STREET ADDRESS	P.O.BOX (IF APPLICABLE)	CITY	STATE	ZIP

INSURANCE INFORMATION

RELATIONSHIP OF STUDENT/STAFF TO INSURANCE SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SUBSCRIBER NAME (IF DIFFERENT THAN ABOVE)	SUBSCRIBER BIRTH DATE	SOCIAL SECURITY #
	__/__/____	

STREET ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP

PHOTO OF CARD (FRONT & BACK) ☐ DRCHRONO ☐ PHOTO COPY ATTACHED ☐ STAFF DEVICE (DEVICE #)

INSURANCE PROVIDER

- ☐ BLUE CROSS BLUE SHIELD (MUSTHAVEPHOTO/COPY OF CARD)
- ☐ UNITED HEALTH CARE
- ☐ MEDICAID: **CIRCLE ONE** *UHC NTC WELLCARE*
- ☐ MEDICARE (SS# REQUIRED)
- ☐ OTHER:________________

SCREENING QUESTIONNAIRE- Questions must be completed before vaccine is administered

	YES	NO	DON'T KNOW
DO YOU HAVE ALLERGIES TO EGGS OR A VACCINE COMPONENT?			
HAVE YOU EVER HAD DIFFICULTY BREATHING AFTER RECEIVING A VACCINATION?			
HAVE YOU HAD A SEIZURE, BRAIN/NERVOUS SYSTEM DISORDER OR GUILLAIN-BARRE?			

I GIVE CONSENT to the **Two Rivers Public Health Department** and its staff to vaccinate the person listed on this form. I have read or had explained to me the Vaccine Information Statement and understand the risks and benefits. I hereby grant permission to Two Rivers Public Health Department to release any pertinent information to the above insurance company upon request and any physicians to whom I might be referred. I understand that if my child is uncooperative or resistant, I will be notified by Two Rivers Public Health Department if vaccine was NOT able to be administered.

X____ ____/____/____

Authorized Signature (*client, if 19 or older, or parent/legal guardian*) Today's Date: *(month/day/year)*

****Child will not be seen without a complete form, parent signature, and copy of insurance****

VACCINE	FORM	AGE	MAN/LOT/EXP	SITE	NURSE/DATE
Sanofi	Fluzone PREFILLED	6 mo+		LA RA	
	FluBlok	18+		LA RA	
	High-Dose	65+		LA RA	
GSK	FluLaval PFS	6 mo+		LA RA	
	MD Vial	6 mo+		LA RA	
	Fluarix / Flucelvax PFS	19+ **AIP**		LA RA	
				LA RA	
				LA RA	
				LA RA	

TRPHD STAFF ONLY - VACCINE RECIPIENT'S TEMPERATURE TODAY: __________

Dr. Chrono_____/_______NESIIS____/___________Billed__________________/_____________ Paid Cash/Donation___________

Special Note:______________________