Adair County Health Department Flu Clinic
Flu Assessment Screening and Consent Form

Name:_____ Date of Birth:_____ Age:_____

Address:_____
City State Zip Code

Phone#:_____ County:_____ Sex: Male / Female

Medicare #:_____ SS#_____

Medicaid #:_____ Do you have Private Insurance? YES NO

Please answer the following questions, if you answer yes, please explain.

1. Do you have a cold cough, fever or chills? Yes or No_____
2. Are you allergic to eggs, chicken, or feathers? Yes or No_____
3. Have you received vaccines or injections in the last 4 weeks?_____
4. Are you taking antibiotics, prednisone, cortisone, anti-cancer or other medications that might prevent you from getting the vaccine? Yes or No_____
5. Have you had the influenza (flu) vaccine before? Yes or No_____
6. Are you pregnant? Yes or No If yes have you checked with your doctor?_____
7. Do you faint with injections? Yes or No_____
8. Do you have asthma or a chronic health condition? Yes or No_____

Please read the following statement & sign below if you agree:
This record will be kept at the Adair County Health Department in a file. It will record when the vaccine was given, the name of the company that made the vaccine, the lot number and who and where the vaccine was given. I have read and or received a copy of the "Vaccine Information Statement", I have had a chance to ask questions and had them answered to my satisfaction. I understand the benefits and risks of the vaccine to be given.

I understand that if I have Medicare and/or Medicaid insurance, my insurance will be billed for the vaccine and injection. I acknowledge by my signature below, that I have been offered a copy of the Adair County Health Department/Home Health Agency "Notice of Privacy Practice Act" and have read the statement above.

_____ _____
Signature of Patient or Parent/Guardian Date

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FOR CLINIC STAFF USE ONLY:

_____Referred for further medical screening
_____Recommended for vaccine
_____No vaccine given

TYPE OF VACCINE: FLU/MANUFACTURE/LOT#/EXPIRATION DATE:

Date Given:_____
Initials of person giving vaccine:_____(see signature, initials & credentials on sign in sheet)

For VFC ONLY on MA/Insured/Uninsured/Underinsured: VIS date_____ Date Given:_____