

**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: \_\_\_\_\_