ADULT 2018/2019 Influenza Vaccine Consent

Cedar County Public Health*400 Cedar St. Tipton, IA*(563) 886-2226

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	GENDER (circle one): Male Female

DATE OF BIRTH:	AGE:	PHONE NUMBER:
___ ___ / ___ ___ / ___ ___ ___ ___		

STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

YOUR CLINIC: (circle one) Clarence Unity Point | Durant Genesis | Tipton Mercy | Tipton Unity Point | West Branch Mercy | Other: _____

PLEASE ANSWER ALL QUESTIONS	CIRCLE ONE	
1. Have you ever had a severe reaction to a previous dose of flu vaccine?	YES	NO
2. Do you have a severe allergy to any components of the flu vaccine? (eggs, gelatin, thimerosal, latex)	YES	NO
3. Are you sick with a fever today?	YES	NO
4. Have you ever had Guillain-Barre Syndrome? (a type of temporary severe muscle weakness)	YES	NO

CONSENT FOR VACCINATION

- The Vaccine Information Statement for the 2018/19 influenza vaccine has been made available. I understand the risks & benefits.
- I give consent to Cedar County Public Health to vaccinate the person named above with the recommended vaccine for his/her age and to record the vaccination in the Iowa Immunization Registry Information System (IRIS).
- I certify that the information I provided for payment is correct. I authorize release of all records required to act on this request. I authorize Medicare, Medicaid, or Blue Cross Blue Shield to make payments directly to Cedar County Public Health. If payment is denied, I am responsible for the charges.

Patient Signature: X _____ **Date:** _____

CHOOSE ONE METHOD OF PAYMENT

◯ **BLUE CROSS/BLUE SHIELD INSURANCE**

IDENTIFICATION NUMBER:

NAME OF CARD HOLDER: | BIRTH DATE OF CARD HOLDER: ___ ___ / ___ ___ / ___ ___ ___ ___

◯ **MEDICARE OR MEDICARE ADVANTAGE**

IDENTIFICATION NUMBER:

◯ **MEDICAID OR MCO** (If an MCO, circle one: **United Healthcare** or **Amerigroup**)

IDENTIFICATION NUMBER: | NAME OF YOUR PHYSICIAN:

◯ **$30 PRIVATE PAY** CIRCLE ONE: CASH CHECK We are not able to accept credit/debit cards

STOP! THIS SECTION FOR OFFICE USE ONLY

Sticker

◯ I have screened this patient for contraindications

◯ Left Arm

◯ Right Arm

Nurse's Signature: Date:

Payment info received	Entered in IRIS	Entered on spreadsheet	Entered in Nightingale	Billed	Payment received