CHILD 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:**

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

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

CONSENT FOR VACCINATION

- The Vaccine Information Statement for the current 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 understand that if my child is younger than 9 years of age and has not had two previous doses of influenza vaccine he/she will require a second dose of the vaccine this season. I am responsible for ensuring that my child receives the second dose.
- 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.

Parent/Guardian Signature: X Date:

CHOOSE ONE METHOD OF PAYMENT

◯ **BLUE CROSS/BLUE SHIELD INSURANCE**

IDENTIFICATION NUMBER:

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

◯ **MEDICAID/MCO** (If an MCO, circle: **United Healthcare** or **Amerigroup**) ◯ **UNINSURED**

IDENTIFICATION NUMBER: **NAME OF YOUR PHYSICIAN:**

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

STOP!	Sticker	FOR OFFICE USE ONLY	Sticker
◯ I have screened this patient for contraindications		SECOND DOSE IF REQUIRED	
Nurse's Signature:		Nurse's Signature:	
Date:		Date:	
◯ Left arm ◯ Right arm ◯ Left thigh ◯ Right thigh		◯ Left arm ◯ Right arm ◯ Left thigh ◯ Right thigh	

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