2024-2025 INFLUENZA CONSENT FORM

Information about person to be vaccinated (please print)

First Name: _____ Age: _____

Last Name: _____ Gender: _____

Date of Birth: _____ Phone #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

For child - Parent's Name: _____

_____ Insurance	Insurance Company Name: _____
_____ Medicaid or Medicare	Policy ID #: _____
_____ No Insurance / Insurance that DOES NOT cover vaccines	Policyholder name: _____
_____ American Indian or Alaskan Native under 18 (VFC eligible)	Policyholder Birthdate: _____
_____ Paid Cash	Relationship: _____

Please answer the following for the person to be vaccinated.

	Yes	**No**
1) Is the person sick today?	____	____
2) Does the person have an allergy to eggs or to a component of the vaccine?	____	____
3) Has the person ever had a serious reaction to influenza vaccine in the past?	____	____
4) Has the person ever had Guillain-Barre syndrome? (Condition in which the immune system attacks the nerves)	____	____

I have been provided a copy of and have read or have had explained to me the information about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I am responsible for any financial charges not covered by my insurance. A record of this immunization will be entered into the Iowa Immunization Registry System (IRIS).

Signature _____ **Date** _____

Person to be vaccinated (If a minor, parent or guardian)

For office use only

Date: _____	**VIS 8/6/2021**
Administered by: _____	
IM Site:	
Left **Deltoid**	
Right **Thigh**	

Billing: ____ IRIS Entry: ____ Location: _____ **Rev. 8/2024**