SEASONAL INFLUENZA VACCINATION
CONSENT 2024-2025
DEWITT- PIATT BI-COUNTY HEALTH DEPARTMENT

PLEASE PRINT CLEARLY!

NAME:____BIRTH DATE:__________ AGE______
(Person receiving vaccination – Name must match Medicare, Insurance or Medicaid Card)

MAILING ADDRESS:____

CITY/STATE/ZIP:____

PHONE:________________________________GENDER: MALE FEMALE (circle one)

____

MEDICARE B or MEDICAID#________________________________

MANAGED CARE ORGANIZATION: ______________________________ID NUMBER: __________

STATE OF ILLINOIS INSURANCE ONLY: Employee _____ Retiree _____ University Staff______

SOCIAL SECURITY NUMBER - Last 4 digits only for state employees: ______________________
Please show your cards to staff for confirmation or copies.

DO NOT WRITE BELOW THIS LINE FOR NURSES USE ONLY

COMMENTS/VACCINE DEFFERAL: ____

____

ROUTE/SITE:

SITE: R. DELTOID/THIGH________________L. DELTOID/THIGH________________

ADMINISTERED BY: ________________________________DATE: ____________________

VIS GIVEN: Inactivated influenza -08/06/2021

Lot # ____________________Manufacturer____________________Exp. Date____________________

Circle correct CPT CODE – 90661 (VFC/317) 90656 (PP) 90662 (High-dose 65+)

Is the client currently sick or have a fever? Yes ___No___

Did the client receive a flu vaccination last year? Yes ___ No ___

Has client ever had an allergic (anaphylactic) reaction to a flu vaccine? Yes ___ No ___

Is the client allergic to eggs or egg products, thimerosal or mercury containing products (such as contact lens solution) or gelatin? Yes___ No___

Does client have a history of Guillain Barre syndrome Yes___ No___

Is the person to be vaccinated younger than age 2 years or older than 49 years? Yes___ No___

Does the client have cancer, leukemia, HIV/AIDS or other immune system problems? Yes__ No____

Does the client have a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (diabetes), neuromuscular disease, or a blood disorder? Is he/she on long term aspirin therapy? Yes___ No___

In the past 3 months has the client taken Prednisone, other steroids, drugs for rheumatoid arthritis, Crohn's disease, or psoriasis, or anti-cancer drugs, anti-viral meds, or radiation treatments? Yes___ No___

Is the client pregnant or could become pregnant in the next month? Yes___ No___

Has the client received vaccinations in the past 4 weeks? Yes___ No___

If the client to be vaccinated is 2 to 4 years of age, has a healthcare provider told you the child has wheezing or asthma in the past 12 months? Yes___ No___

Does the client to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (an isolation room of a bone marrow transplant unit)? Yes__ No___

I have read the information or have had the information explained to me. I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me, or to the person named above for whom I am authorized to make this request. I accept responsibility for seeking medical attention for any problems with this vaccination. I authorize billing of this vaccination to my health insurance. I acknowledge I have received, or requested, a copy of the DeWitt-Piatt Bi-County Health Department Notice of Privacy Practices.

X________________________________ X________________________

AUTHORIZING SIGNATURE ***DATE***