

# Flu Signature Form

<hr/> First Name	<hr/> Last Name	<hr/> Initial	<hr/> Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female
<hr/> Parent/Guardian Name (if client is a minor)			<hr/> Date of Birth	<input type="checkbox"/> Responsible Person
<hr/> Address	<hr/> City	<hr/> State	<hr/> Zip Code	
<hr/> Phone Number <input type="checkbox"/> cell <input type="checkbox"/> home <input type="checkbox"/> YES you may send text message reminders to this phone number				
<hr/> Name of Insurance Company		<hr/> Identification Number		<hr/> Group Number
<hr/> Name of Policy Holder		<hr/> Policy Holder's DOB		<b>***NOTE: Without insurance information you will be billed directly for your flu shot.</b>

**For patients:** The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please see the back side of this page or ask your healthcare provider to explain it.

YES	NO	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever had a severe reaction after receiving a vaccination (i.e., rash, hives, difficulty breathing)? <b>Please list reaction(s):</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (i.e., diabetes), anemia, other blood disorder or a chronic condition you see a provider for? <b>Please list your chronic condition(s):</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Are you sick today with a fever or diarrhea?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? <b>Please list:</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. In the <b>past 3 months</b> , have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments? <b>Please list medication(s):</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Do you have allergies to any of the following? <b>Please circle which one(s):</b> latex / neomycin / gentamicin / yeast / gelatin / monosodium glutamate / eggs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. <b>For adults:</b> Have you received a Pneumococcal vaccine? <b>Please complete:</b> <input type="checkbox"/> Prevnar 13 Date: _____ (released 08/2014) <input type="checkbox"/> Pneumovax 23 Date: _____ (released 1983)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. <b>For women:</b> Are you pregnant or a chance you could become pregnant during the next month?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Have you had a seizure, a brain, or other nervous system problem?

**\*FOR OFFICE USE ONLY\***

	Site	Lot #		Site	Lot #
Flu / I-Flu / H-Flu:	_____	_____	Pneu23 / Prev13:	_____	_____
Flumist:	_____	_____	Other:	_____	_____
Other:	_____	_____	RN Signature:	_____	_____



## CLIENT CONSENT

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Patient DOB

\_\_\_\_\_  
Parent Name If Minor (Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### CONSENT FOR MEDICAL SERVICES

#### Immunization Services

- I have been offered copies (electronic and/or paper) of the Vaccine Information Statements for all vaccines being given today.
- I understand that vaccines are not mandatory and may be refused for religious and/or other grounds.
- I understand the benefits, risks, or complications from vaccines. (Further information about the vaccines being offered is available upon request).
- I understand that all immunization records will be entered into the IRIS (Immunization Reminder Information System). Participation in the immunization registry is voluntary. To have your records removed from IRIS, you must contact the Idaho Immunization Program.
- I have been offered a copy of SCPHD's Notice of Privacy Practices.
- I consent to receive vaccinations provided by SCPHD for myself or for this child for whom I am the parent or legal guardian.

### FINANCIAL CONSENT

- SCPHD will bill your insurance company for you, and the payment may come directly to SCPHD.
- SCPHD may not be considered an In-Network provider and therefore cannot guarantee coverage by your insurance company.
- Whether your insurance company pays or not, your account balance is your responsibility.
- Some, or perhaps all, of the services provided may be non-covered services.
- Confidentiality cannot be guaranteed with insurance billing. Your insurance provider may send information to the holder of the insurance policy (who may be your parent, guardian or spouse).

I have read the Financial Consent. I understand and agree to this policy. I also understand that I will be responsible for payment of all services. I authorize release of medical information necessary to process medical claims and authorize payment of benefits to SCPHD.