Flu Shot Consent Form – **PRINT ONLY – SIGN BACK**

Patient First Name | **Patient Last Name** | Initial | **Patient Date of Birth** | ☐ Male ☐ Female

Parent/Guardian Name (if client is a minor) | Date of Birth | ☐ Responsible Party

Mailing Address | City | State | Zip Code

Phone Number

DOES PATIENT HAVE NSURANCE **Y** **N**

** **For Tricare use benefits number from BACK of card****

*****NOTE: Without insurance information you will be billed directly for your flu shot***** (Adult -$40; 65+Hi-Dose $83; all Kids $20). Please call our office to make financial arrangements or to update your insurance information. No child (18 yrs and under) will be denied a flu shot due to inability to pay.

Name of Insurance Company | Member ID Number

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	
☐	☐	☐	1. Have you ever had a severe reaction after receiving a vaccination (i.e., rash, hives, difficulty breathing)? ***Please list reaction(s):***
☐	☐	☐	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? ***Please list your chronic condition(s):***
☐	☐	☐	3. Are you sick today with a fever or diarrhea?
☐	☐	☐	4. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? ***Please list:***
☐	☐	☐	5. In the ***past 3 months***, 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? ***Please list medication(s):***
☐	☐	☐	6. Do you have allergies to any of the following? ***Please circle which one(s):*** latex / neomycin / gentamicin / yeast / gelatin / monosodium glutamate / eggs
☐	☐	☐	7. ***For adults 65+ years*:** Have you received a Pneumococcal vaccine? (Not Sure_____) ☐ Prevnar 13 Date: _____ (released 08/2014) ☐ Pneumovax 23 Date: _____ (released 1983)
☐	☐	☐	8. ***For women:*** Are you pregnant or a chance you could become pregnant during the next month?
☐	☐	☐	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:		

South Central Public Health District
Prevent. Promote. Protect. phd5.idaho.gov

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CLIENT CONSENT

Vaccine information sheets can be found at:

https://www.immunize.org/vis/vis_flu_inactive.asp (injectable)

https://www.immunize.org/vis/vis_flu_live.asp (mist)

School based clinics for 18 years and under will administering flu mist only

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 SCHPD'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 and Medical Consent and I understand and agree to these policies. 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.

_____ _____

Signature (If minor, signature of responsible party) Date

TWIN FALLS: 208.737.5966 HEYBURN: 208.678.8221 GOODING: 208.934.4477

JEROME: 208.324.8838 BELLEVUE: 208.788.4335