COVID-19 + FLU VACCINE CONSENT FORM

Please complete form with information about the person who is receiving the vaccine (please print)

Clinic Use: M12+ M6m-11y
Nvx Pf12+ Pf5-11y Pf6m-11y
6m-4yo Dose: 1st 2nd 3rd

Name: _____ **Birth Date**: _____ **Age**: _____ **Sex**: ☐M ☐F ☐Other

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity**: ☐Hispanic ☐Non-Hispanic

Mailing Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone: _____ **Do you have Medicare or Medicaid?** ☐No ☐Yes--Number:_____

Do you have insurance? ☐No ☐Yes Company:_____ Policy/ID#:_____

Please list policyholder name, date of birth & address, if not you: _____

The following questions will help determine if there is any reason you should not receive a COVID immunization injection.
Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

Have you received a dose of a COVID-19 vaccine before? If Yes, Date of most recent dose:_____	☐ No ☐Yes
Do you have a moderate/severe immunocompromising condition? (for example, cancer treatment, organ transplant, etc.)	☐ No ☐Yes
Do you have an allergy to any medications, vaccine, food, or latex? List all allergies: _____	☐ No ☐Yes
Have you ever had a serious reaction to any vaccine or injectable therapy?	☐ No ☐Yes
Are you sick today? Do you have a fever?	☐ No ☐Yes
Do you have a history of myocarditis or pericarditis?	☐ No ☐Yes
For Age 6mo – 4yrs only: How many doses of a previous COVID vaccine? ☐0 doses ☐1 dose ☐2 doses ☐3 doses Date of dose 1:_____ Date of dose 2:_____ Date of dose 3:_____ Vaccine Brand:_____	

Have you received influenza (flu) vaccine before?	☐ No ☐Yes
Have you ever had Guillian-Barre Syndrome?	☐ No ☐Yes
Have you ever felt dizzy or faint before, during, or after a shot?	☐ No ☐Yes
Are you anxious about getting a shot today?	☐ No ☐Yes
If an adult over 65, have you received a Pneumonia vaccine? If yes, in what year? PPSV23 _____ PCV15 or PCV20_____	☐ No ☐Yes

By signing below, I consent to the _____ County Public Health Office (PHN) administering the current vaccinations to me. In addition, I read or have had explained to me and understand the Vaccine Information Statement(s) for the vaccine(s) that the PHN is administering today. A healthcare professional also provided education and counseling on each vaccine and thoroughly answered my questions.

Client/Guardian Signature: _____Date_____

Receipt of the Notice of Privacy Practices:
The Notice of Privacy Practices explains how WDH may use or disclose information. Not all situations may be described. WDH is required to furnish its clients with a notice of privacy practices pertaining to information we use, maintain and disclose.
I have received a copy of the WDH Notice of Privacy Practices and have had an opportunity to ask questions regarding how my information will be used. By signing below, I acknowledge receipt of the Notice of Privacy Practices.

COVID-19 + FLU VACCINE CONSENT FORM

Client Signature: _____Date_____

Please continue on the back of this form

Name: _____ **Birth Date**: _____

Billing Authorization

By signing below, I authorize the PHN to bill my insurance company for the vaccine(s) administered to me. I also authorize the PHN to disclose my protected health information to my insurance company for payment purposes. I authorize my insurance benefits to be paid directly to the PHN. In the event that the service is not covered, I am aware that I am financially responsible for any and all services provided to me.

Client Signature: _____Date_____

Clinic Use Only

Clinic site: _____ ***Date of vaccine***: _____

VFC Eligibility Screening for 18 years and under ONLY: *(if any of the following apply, patient is VFC Eligible):*

Medicaid Uninsured American Indian/Alaska Native Under-Insured (Insurance does not cover)

If none of above, not eligible to receive VFC COVID Vaccine

COVID VACCINE: ***Another dose required? Yes No Date:_____***

Vaccine Stock Type: Private-Adult Private-Pediatric Adult Bridge VFC

Dose: ☐Pfzr Yellow Cap 0.3ml (6m-4y) ☐Pfzr Blue Cap 0.3ml (5-11y) ☐Pfzr 0.3ml (12+y)

☐M 0.25ml/25mcg (6m-11y) ☐M 0.5ml/50mcg (12+yrs) ***Comments:***

☐Nvx 0.5ml (12+yrs) ☐Nvx Bstr 0.5ml (18+yrs)

Site of IM injection: ☐RDT ☐LDT ☐RVL ☐LVL ***VIS/EUA Fact Sheet Provided***: *Yes No* ***Lot number***: _____

Signature & title of vaccine administrator: _____

INFLUENZA VACCINE:

Booster Required? Yes No Date:_____

Vaccine:_____ *Vaccine Stock Type: Private-Adult Private-Pediatric Adult Free VFC*

Dose: ☐0.25ml ☐0.5ml ☐0.7ml High Dose ***Comments:***

Site of IM injection: ☐RDT ☐LDT ☐RVL ☐LVL ***VIS/EUA Fact Sheet Provided***: *Yes No* ***Lot number***: _____

Signature & title of vaccine administrator: _____

Dosage Schedule for Influenza Vaccine:

Age Group	Dosage Schedule
9 Years and older	0.5ML: One dose
3-8 Years	0.5 ML: One dose*
6 Months - 35 Months	0.25 ML or 0.5 ML: One dose*†

** For children younger than 9 years of age, refer to the most recent ACIP Recommendations to determine the need for one or two doses. If two doses are needed, separate the doses by at least 4 weeks.*

†Dosage for age may vary by brand of vaccine. See package insert.

Billed ☐ WYIR ☐