

## Darren Health Department INFLUENZA IMMUNIZATION CONSENT FORM

Name (please print) _____	Date of Birth _____
Street Address _____	City/State _____ Zip Code _____
	Sex _____ Phone _____

**Please show proof of Medicare card!**

MEDICARE Part B					SELF PAY
<div style="border-bottom: 1px solid black; width: 80%; margin-bottom: 5px;"></div> Medicare Number				<div style="border-bottom: 1px solid black; width: 80%; margin-bottom: 5px;"></div> _____	<input type="checkbox"/> Cash  <input type="checkbox"/> Check #

<b>Do you have allergies to eggs or other substances?</b>	<b>No</b>	<b>Yes</b>
<b>Have you ever had a serious reaction to a flu shot?</b>	<b>No</b>	<b>Yes</b>
<b>Have you ever had a neurological disease or Guillian-Barre Syndrome?</b>	<b>No</b>	<b>Yes</b>
<b>Are you sick with a fever?</b>	<b>No</b>	<b>Yes</b>
<b>Are you pregnant?</b>	<b>No</b>	<b>Yes</b>
<b>Is this your first flu shot?</b>	<b>No</b>	<b>Yes</b>
<b>Are you the age of 9 or under?</b>	<b>No</b>	<b>Yes</b>

I have read, or had explained to me, the information sheet about **influenza (flu)** vaccine. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described. I request that the **flu** vaccination be given to me (*or the person named above for whom I am authorized to make this request*). I authorize the release of any medical or other information necessary to process a Medicare or insurance claim or for other public health purposes. **In the event that my insurance does not cover the cost of my vaccine, I agree to make payment.**

\_\_\_\_\_  
Signature of recipient (or parent or guardian) \_\_\_\_\_  
Date

Injection Site: <input type="checkbox"/> Left Arm <input type="checkbox"/> Right Arm
Manufacture & Lot Number: _____ MD/Nurse Signature: _____ Date _____