Date:_____ Chart #: _____

Office Use Only: ☐ VFC ☐ PRIVATE

Marquette County Health Department Seasonal Influenza Vaccine Program

Patient Legal Name: _____**Date of Birth:** _____**Age:**_____

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

Phone: _____**Sex:** ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ White ☐ Asian ☐ Black/African American ☐ Native Alaskan/American Indian ☐ Native Hawaiian/Pacific Islander

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Are you enrolled in any of the following? (Please present your insurance card to registration)

☐ Medicaid ☐ Medicare Part B ☐ No Medical Insurance ☐ Cash/Check/Credit

☐ Insurance **WITH** Immunization Coverage ☐ Insurance **WITHOUT** Immunization Coverage

***Attach copy of insurance card or provide the following information**:

Insurance Carrier Name: _____**Policy #:** _____

Card Holder's Name: _____**Card Holder's Date of Birth**: _____/_____/____

Card Holder's Phone #: _____ **Relationship to Patient**: _____

Medical Screening Questionnaire & Consent for Vaccination

YES	NO	
		1. Has the person to be vaccinated ever had a serious reaction to influenza vaccine?
		2. Does the person to be vaccinated have an allergy to a component of the vaccine? (Such as egg) If so, what was the reaction? _____
		3. Has the person to be vaccinated ever had Guillain-Barre syndrome (GBS)?
		4. Is the person to be vaccinated sick today?

"I have read or have had explained to me the information in the vaccine information statement (VIS). I have also had a chance to ask any questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine." *(Initial here)* _____

"Marquette County Health Department has made their Privacy Act practices available to me." *(Initial here)* _____

"I authorize the release of any medical or other information with respect to this vaccine to Medicare, Medicaid or other third party payer as needed to request payment of authorized benefits to be made on my behalf to Marquette County Health Department. I acknowledge that if my insurance does not cover the cost of administering the vaccine then I will be responsible for any balance on my account for which I will receive a statement."

_____ _____

Signature of Responsible Party **Date**

_____ _____

Printed Name of Responsible Party **Phone (If different than above)**

THIS SIDE OF FORM TO BE COMPLETED BY MARQUETTE COUNTY HEALTH DEPT STAFF ONLY

Nurse Staff:_____ **Date Vaccine Administered:** _____

Vaccine	Manuf.	Lot #	Route	Site	Nurse Signature
IIV4 0.5mL	Sanofi		IM	RD LD RT LT	
High Dose (IIV3) 0.5mL (65 and up)	Sanofi		IM	RD LD RT LT	

Nurse Notes:

_____

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