

MIIC Entry Date _____

Claim entry Date _____

2016-17 Flu Shot Consent Form – Screening Questions on Reverse Side

Carlton County Public Health & Human Services

I have had an opportunity read the Influenza Vaccine Information Sheet and ask questions. I understand the benefits and risk of influenza vaccination as described. I acknowledge that I understand the purposes/benefits of my state's immunization registry(*State registry) and my states health information exchange (*State HIE*)and the applicable Provider may disclose my immunization information to the State Registry, to the State HIE, or through the State HIE, to the State Registry, for the purposes of public health reporting or to my health care providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I request that the vaccine be given to me or to the person named below for whom I am authorized to sign. If applicable, I authorize release of information from Carlton County Public Health to my health insurance company to facilitate collection of payment for services. I authorize payment to be made directly to Carlton County Public Health.

Last Name (Please Print) _____ First _____ MI _____ Date of Birth _____ Age _____ Gender _____

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Signature of person receiving vaccine (or parent/guardian) _____

Private Insurance Name: _____

ID# (include all prefixes) _____ Group # _____

Medical Assistance (PMI) #: _____

PMP or MSHO or MSC+: Blue Plus HealthPartners Other: _____

ID# (include all prefixes) _____ Group # _____

Medicare Number(card is red/white/blue): _____

Medicare Advantage Plan Name: _____

ID# (include all prefixes) _____ Group # _____

OFFICE USE ONLY

FluZone ® Sanofi Pasteur: L R Deltoid/Vastus IM Location:Home/Clinic Lot No: _____

Dose:0.5ml 0.25mlNurse: _____

(title)Date: _____

EXP.Date: _____

___ Influenza Vaccine Information Sheet (8/07/15) and Privacy Form were given

Seasonal Flu Vaccine 1st dose _____ Seasonal Flu Vaccine 2nd dose _____

Please circle:

Private
(Insured status)

Employee

MnVFC
(6mo.-18yr.)

___ Uninsured

___ American Indian/AlaskanNative

___ MHCP/MA/MNCare

___ Insurance doesn't cover flu vaccine

___ Insurance vaccine cap met

Amount Paid: _____

MnVFC UAV*
(19+yr.)

___ Uninsured

___ Insurance doesn't cover flu vaccine

___ Insurance vaccine cap met

*Adults ages 19 + who are AI/AN or on MHCP/MA/MNCare or Medicare receive private vaccine

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month / day / year

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer “yes” to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____