NCDHD
North Central District
Health Department

Vaccination Consent Form – Adult (19+)
Influenza Vaccine

LAST NAME	FIRST NAME	MIDDLE INITIAL

AGE	BIRTHDATE	GENDER (circle) Male/Female

STREET ADDRESS	MAILING ADDRESS (IF DIFFERENT)

CITY	STATE	ZIP	PHONE #

MOTHER'S MAIDEN NAME (First and Last):	Primary language, if other than English:	ETHNICITY: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

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

2.	Are you sick today?		YES	NO
3.	Do you have allergies to medications, gelatin, yeast, eggs, latex or any vaccine?		YES	NO
4.	Have you ever had a serious reaction to a vaccine in the past?		YES	NO
5.	Have you had a seizure or a neurological problem?		YES	NO
6.	Do you have cancer, leukemia, AIDS or any other immune system problem?		YES	NO
7.	Do you take cortisone, prednisone, other steroids, anticancer drugs or X-Ray treatment?		YES	NO
8.	Have you received a transfusion of blood or blood products or been given immune (gamma) globulin or an antiviral drug in the past 6 months?		YES	NO
9.	Are you pregnant or is there a chance you could become pregnant during the next 3 months?	NA	YES	NO
10.	Have you had chicken pox?		YES	NO
11.	Have you ever had Guillian-Barre syndrome?		YES	NO
12.	Have you received vaccinations in the past 4 weeks?		YES	NO

INSURANCE QUESTIONS

Do you have health insurance, including Medicaid or Medicare?	**YES**		**NO**
If yes, does your health insurance cover vaccines?	**YES**	**YES, BUT NOT ALL**	**NO**

I GIVE CONSENT to North Central District Health Department and its staff to vaccinate the person listed on this form. I have received and read or had explained to me the Vaccine Information Statement(s) and understand the risks and benefits. I also acknowledge that North Central District Health Department has made their Notice of Privacy available for review. I understand that I may request a copy of the Notice of Privacy. I hereby grant permission to North Central District Health Department to release any pertinent information to the insurance carrier listed on the reverse side upon request and any physicians to whom I might be referred. If not eligible for Vaccines for Children Program (VFC) or Adult Immunization Program (AIP), I understand that I am responsible for charges not paid by my insurance company.

Signature:	Date:

WE REQUEST THAT YOU STAY ON SITE FOR 10 MINUTES AFTER RECEIVING YOUR VACCINATION(S). IF YOU CHOOSE TO LEAVE, YOU ASSUME ALL RESPONSIBILITY/LIABILITY FOR ANY ADVERSE EVENT. THANK YOU.

Fill out the following information for the Primary Insurance Policy Holder (if not the same person receiving the vaccination)

Primary Policy Holder- Name as appears on the card _____

Date of Birth _____ **Gender** _____M _____F

Address _____ **Mailing Address (if different)** _____

_____ _____

Phone number_____

ADMINISTRATIVE USE ONLY

CHECK VACCINES TO BE RECEIVED:

For Influenza Vaccine ONLY!

If client is receiving other vaccinations at this clinic, please fill out the separate Additional Vaccination Form!

Vaccine Name	Manufacturer	Lot Number	Expiration Date	Date Given	Site	
	GSK Merck Sanofi Pasteur				RA	LA
					RT	LT
Nurse Signature:						

CLINIC SITE:	NESIIS Entry Date:	Billed Date:
	NESIIS Entry Initials:	Billed Initials:

Payment Information (check all that apply):			
☐ Cash	**For insurance, including Medicaid or Medicare, fill out information to right:**	Insurance Company:	☐ Mcaid ☐ Mcare ☐ Other
☐ Check		Primary Policyholder	
☐ Donation		Relationship to Insured	☐ Self ☐ Spouse ☐ Parent
☐ VFC		Policy/Member #	
☐ AIP		Group #	
☐ Insurance		Payer ID	
☐ Bill to:			

Once payment is received, the immunizations on this sheet will need to be placed in class 803