

2024-2025 Influenza Vaccine Consent Form

Sumner County Health Department, 217 W. 8th St., Ste 1, Wellington, KS 67152

Office Use Only	
Type of Vaccine:	___ High Dose 65 yrs. & > ___ Quad 06 mo. & > ___ Flublok
Pay Source:	___ M-Care ___ RR M-Care ___ M-Caid ___ Sumner Co. ___ PP ___ 317 ___ Ins. _____ ___ Business _____

***SECTION 1: PATIENT INFORMATION (Please Print)**

FIRST NAME:	LAST NAME:	(M.I.)	PATIENT'S DATE OF BIRTH & AGE ____/____/____ AGE: _____	
HOME ADDRESS	CITY	STATE	ZIP CODE	PATIENTS GENDER M / F
PHONE NUMBER:	DOCTOR'S NAME AND PHONE NUMBER		Commercial Insurance Number: (Proof of Insurance required)	
Medicare Number: (Proof of Insurance required)	Medicaid Number: (Proof of Insurance required)		Policy Holder: _____ DOB: ____/____/____	

***SECTION 2: The following questions will help us determine your eligibility to be vaccinated today.**

	YES	NO
1. Do you have allergies to food, medications, latex or vaccines? (Examples: eggs, latex gloves, neomycin, yeast, thimerosal) If yes, please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any health conditions such as asthma, diabetes or heart disease? If yes, please list: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a flu shot before?	<input type="checkbox"/>	<input type="checkbox"/>
4. If yes to the previous question, did you have a serious reaction? Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had Guillain-Barré Syndrome (a condition that causes paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>

***SECTION 3: CONSENTS AND ACKNOWLEDGEMENTS**

CONSENT for VACCINATION, ACKNOWLEDGMENT of VACCINE INFORMATION STATEMENT, NOTICE of PRIVACY PRACTICES and CONSENT (if applicable) to bill Medicare:

- I give my consent for vaccination with the Influenza vaccine. I also give my consent for the information contained on this form to be released to the Kansas Immunization Registry for the purposes of assessment and reporting.
- I acknowledge receipt of the Sumner County Health Department's Notice of Privacy Practices and understand that I can request another copy at any time by contacting the Privacy Officer at 620.326.2774.
- I have been offered a copy of the Influenza "Vaccine Information Statement". I have read or had it explained to me and understand the information on the "Vaccine Information Statement".
- I understand if my insurance claim(s) are denied or if I have insurance co-pays that I am responsible for payment and will make prompt payment when billed.

MEDICARE RECIPIENTS ONLY: (Check box) I authorize Sumner County Health Department to bill Medicare for my Influenza Vaccination.

Signature of Patient or Parent/Guardian: _____ Date _____

Printed Name of Parent or Guardian: _____

SECTION 4: ADMINISTRATIVE USE ONLY – To be completed by Healthcare Professional

Vaccine	Date Dose Administered	Route	Dose Number (1st or 2nd)	Vaccine Name/Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2024-2025 Influenza		IM R L		<input type="checkbox"/> Prefilled <input type="checkbox"/> Multi-dose		