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_____

2023-2024 Influenza Vaccine Consent Form

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

*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) _____ Policy Holder: _____ DOB:_____/_____/_____	
Medicare Number: (Proof of Insurance required)	Medicaid Number: (Proof of Insurance required)			

*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: _____	☐	☐
2. Do you have any health conditions such as asthma, diabetes or heart disease? If yes, please list: _____	☐	☐
3. Have you ever had a flu shot before?	☐	☐
4. If yes to the previous question, did you have a serious reaction? Describe: _____	☐	☐
5. Have you ever had Guillain-Barré Syndrome (a condition that causes paralysis)?	☐	☐

*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
2023-2024 Influenza		IM R L		☐ Prefilled ☐ Multi-dose		