Floyd Valley Healthcare

Billing _____
IRIS _____
HM _____

Influenza Vaccine Consent Form

I have been given a copy of the Influenza Vaccine Information Statement. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of Influenza Vaccine and request that this be given to me or to the person named below for whom I am authorized to make this request.

Porfavor utilice letra de molde clara

Nombre:_____

Fecha de Nac _____ **Edad:**_____ ☐ **Masc.** ☐ **Femenino**

Direccion:_____

Ciudad/Estado/CP:_____ **Tel:** _____

Doctor: _____

1. **Tiene alguna alergia al huevo?** **Si** **No**
2. **Ha presentado una reaccion alergica despues de la vacuna?** **Si** **No**
   (falta de aire, ronchas, dificultad para respirar etc.)
3. **Se ha paralizado por el Syndrome de Guillain-Barre 6 semanas después** **Si** **No**
   De recibir la vacuna?
4. **Se siente bien hoy?** **Si** **No**

Firma X_____ **Fecha** _____ **Hora**_____

(Paciente o Padre o Tutor)

For Office Use Only:

☐ **Private Insurance**
Company _____ **Policy #** _____
☐ **Medicare**
Company _____ **Policy #** _____
☐ **Medicaid**
Company _____ **Policy #** _____
☐ **No Insurance/Underinsured** **Employee of:**
☐ **VFC** ☐ **Self-Pay** ☐**Donegal Ins.** ☐**City of LeMars**

For Nurse Use Only:

☐ **Flulaval**-Private Lot# 495MK ☐ VFC Lot#: 2XK44; 332H7; 774N2
☐ **FluBlok** Lot# TFAA2413; TFAA2423; TFAA2435
☐ **Fluad** (65 yrs and older) Lot# 388472, 388464

IM Injection Site: (circle) RD LD

Date Vaccinated: _____ **Nurse Signature:** _____

CONSENT