Health Department Staff Only

Place sticker here

VHN #: _____

Nurse: _____

Date: _____

Injectable

VFC / PRIVATE

Georgia Department of Public Health
District 4 Public Health

Lamar County Health Department

Annual Influenza Vaccine Consent Form – Injectable Flu Shot

Legal Name Only- Please Print in blue or black ink only. (No pencil)

Last name_____

First name _____Middle name_____

Date of birth _____ Age _____ Race_____

Male / Female Home/Cell number _____

Address _____

City_____ Zip code_____

Emergency Contact:

Name _____Number _____

Georgia Medicaid # _____

Amerigroup, Medicaid, PeachCare, PeachState, CareSource

Circle Insurance coverage

Aetna / Cigna / Coventry / Blue Cross Blue Shield / United Health Care /UMR/Medicare

Policy # _____

Policy Holder Name _____

Policy holder Date of Birth _____

**We will make every effort to bill your insurance company. If claim is denied, a bill and copy of the EOB will be mailed to you.*

*Other insurance coverage not listed above, the cost will be $30.00
*No insurance for a child will be $21.93

ANSWER ALL QUESTIONS

Please check if any of the following restrictions apply to the person receiving vaccine:

__ 50 years of age or older

__ Asthma or under 5 years of age with wheezing in the past year

__Pregnant

__ Received any vaccines in the last 30 days

__ Any long term health problems affecting the immune system (heart, lung, kidney, neurovascular, metabolic-diabetes, or blood disease- sickle cell or HIV, other _____

__ Long term aspirin therapy

__ Close contact with patients requiring a protected environment (bone marrow transplant, chemo for cancer, etc.)

__ Serious allergy to eggs, medication, gelatin or another vaccine component

__ History of Guillain-Barre Syndrome or serious reaction to the flu vaccine in the past.

__ NONE OF THE ABOVE

Consent for Seasonal Influenza Vaccine Shot

_____ I GIVE CONSENT _____I DO **NOT** GIVE CONSENT

I have received the CDC vaccine information statement. I have had the opportunity to ask questions and understand the benefits and risks of the flu vaccine. I request and voluntary consent that the flu vaccine be given to the person above. I authorize the release of information from public health as required by law, for data collection and filing of claims for reimbursement directly from Medicaid or my insurance provider if applicable. I hereby release the school system, public health, participating nursing school, program and clinic volunteers from any and all liability

Signature _____

Print Name: _____ Date: _____