COVID-19 + FLU VACCINE CONSENT FORM

Please complete form with information about the person who is receiving the vaccine (please print)

Clinic Use: M12+ M6-11 M<6
JJ Nvx Pf12+ Pf5-11 Pf<5
Dose: 1st 2nd Add'l Bstr 1 Bstr 2

Name: _____ **Birth Date**: _____ **Age**: _____ **Sex**: ☐M ☐F ☐Other

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity**: ☐Hispanic ☐Non-Hispanic

Mailing Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone: _____ **Do you have Medicare or Medicaid?** ☐No ☐Yes--Number:_____

Do you have insurance? ☐No ☐Yes Company:_____ Policy/ID#:_____

Please list policyholder name, date of birth & address, if not you: _____

The following questions will help determine if there is any reason you should not receive a COVID immunization injection.
Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask a healthcare provider to explain.

How many doses of a COVID-19 vaccine have you received? ☐0 doses ☐1 dose ☐2 doses ☐3 doses ☐4 doses Date of dose 1:_____ Date of dose 2:_____ Date of dose 3:_____ Date of dose 4:_____ Type of dose 1:_____ Type of dose 2:_____ Type of dose 3:_____ Type of dose 4:_____	
Do you have a moderate/severe immunocompromising condition? (for example, cancer treatment, organ transplant, etc.)	☐ No ☐Yes
Do you have an allergy to any medications, food, vaccine, or latex? List all allergies: _____	☐ No ☐Yes
Have you ever had a severe reaction to any vaccine or injectable therapy?	☐ No ☐Yes
Are you sick today?	☐ No ☐Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No ☐Yes
Do you have a history of myocarditis or pericarditis?	☐ No ☐Yes

Additional Questions for Influenza Vaccine:

Have you received influenza (flu) vaccine before?	☐ No ☐Yes
Have you ever had a serious reaction to influenza vaccine in the past?	☐ No ☐Yes
Have you ever had Guillian-Barre Syndrome?	☐ No ☐Yes
If an adult over 65, have you received a Pneumonia vaccine? If yes, in what year? PPSV23 _____ PCV15 or PCV20_____	☐ No ☐Yes

By signing below, I consent to the Sublette County Public Health Office (PHN) administering the current vaccinations to me. In addition, I read or have had explained to me and understand the Vaccine Information Statement(s) for the vaccine(s) that the PHN is administering today. A healthcare professional also provided education and counseling on each vaccine and thoroughly answered my questions.

Client/Guardian Signature: _____Date_____

Billing Authorization

By signing below, I authorize the PHN to bill my insurance company for the vaccine(s) administered to me. I also authorize the PHN to disclose my protected health information to my insurance company for payment purposes. I authorize my insurance benefits to be paid directly to the PHN.

Client Signature: _____Date_____

Please continue on the back of this form

Receipt of the Notice of Privacy Practices:

The Notice of Privacy Practices explains how WDH may use or disclose information. Not all situations may be described. WDH is required to furnish its clients with a notice of privacy practices pertaining to information we use, maintain and disclose.

I have received a copy of the WDH Notice of Privacy Practices and have had an opportunity to ask questions regarding how my information will be used.

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

Client Signature: _____Date_____

Clinic Use Only

Clinic site: _____ ***Date of vaccine:*** _____ ***Date next dose due:*** _____

COVID VACCINE:

Dose: ☐Pfzr 3mcg/0.2ml (6m-4y) ☐Pfzr 10mcg/0.2ml (5-11y) ☐Pfzr 30mcg/0.3ml (12+y) ☐Pfzr BiV. Bstr 30mcg/0.3ml (12+y)
☐M 25mcg/0.25ml (6m-5y) ☐M 50mcg/0.5ml (6-11y) ☐M 100mcg/0.5ml (12+y) ☐M BiV. Bstr 50mcg/0.5ml (18+yrs)
☐J&J 0.5ml (18+yrs) ☐Nvx 0.5ml (12+yrs)

Site of IM injection: ☐RDT ☐LDT ☐RVL ☐LVL ***VIS/EUA Fact Sheet Provided:*** *Yes No* ***Lot number:*** _____

Signature & title of vaccine administrator: _____

Comments:

INFLUENZA VACCINE:

Booster Required? Yes No Date:_____

Vaccine:_____

Dose: ☐0.25ml ☐0.5ml

Site of IM injection: ☐RDT ☐LDT ☐RVL ☐LVL ***VIS/EUA Fact Sheet Provided:*** *Yes No* ***Lot number:*** _____

Signature & title of vaccine administrator: _____

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Dosage Schedule for Influenza Vaccine:

Age Group	Dosage Schedule
9 Years and older	0.5ML: One dose
3-8 Years	0.5 ML: One dose*
6 Months - 35 Months	0.25 ML or 0.5 ML: One dose*†

** For children younger than 9 years of age, refer to the most recent ACIP Recommendations to determine the need for one or two doses. If two doses are needed, separate the doses by at least 4 weeks.*

†Dosage for age may vary by brand of vaccine. See package insert.

VFC Eligibility Screening if applicable: *(if any of the following apply, patient is VFC Eligible):*

☐ **Medicaid** ☐**Uninsured** ☐**American Indian/Alaska Native** ☐**Under-Insured** (Insurance does not cover vaccines needed)

If none of above, not eligible to receive VFC Influenza Vaccine.