CONSENT TO RECEIVE INFLUENZA VACCINE 2020 / 2021

Rice County Public Health
320 NW Third St; Suite 1
Faribault, MN 55021
507-332-6111
www.co.rice.mn.us

Last Name (*please print*)	**First Name**	**Middle Initial**	**Birth Date** *(mo/day/year)*	**Age**

Street Address	**Phone**	**Male** ☐ **Female** ☐

City	**State**	**Zip Code**

Rice County Public Health participates in the Minnesota Immunization Information Connection (MIIC). Immunization data may be shared with MIIC, other healthcare providers, schools, and health departments directly involved in keeping you up-to-date with immunizations. Information you provide is private and is not shared with others except as needed for payment, treatment, and agency operations. A copy of Rice County Public Health Notice of Privacy Practices is available upon request and is posted on our website at: www.co.rice.mn.us/DocumentCenter/View/821/Privacy-Practices-PDF

Check vaccine interested in*

- ☐ **High Dose – Only for 65 yrs & older**
- ☐ **Quadrivalent Injectable – 6 mo. & older**
- ☐ **FluMist – Ages 2 yrs thru 49 yrs**

***Vaccines subject to availability & program guidelines.**

RCPH bills to Medicare, MA, Health Partners, Blue Cross, Medica

Payment Information **Check 1st Applicable**

- ☐ **Medicare B ID#**_____
- ☐ **MA, UCare, Blue Plus, Medica** _____
- ☐ **Private Pay: $38 Quadrivalent/$80 High Dose**
- ☐ **Uninsured**

PLEASE COMPLETE THESE QUESTIONS:

1. Are you allergic to Thimerosol, Formaldehyde or egg protein? ☐ yes ☐ no
2. Have you ever had a systemic allergic reaction (anaphylaxis) to eggs? ☐ yes ☐ no
3. Have you ever had a severe reaction to flu vaccine or any other immunization? ☐ yes ☐ no
4. Have you ever had Guillain-Barre Syndrome or "French Polio?" ☐ yes ☐ no
5. Do you have a fever, or are you ill today? ☐ yes ☐ no

ADDITIONAL QUESTIONS FOR FLUMIST (AGE 2 – 49)

1. Are you pregnant or is there a chance you are pregnant? ☐ yes ☐ no
2. Are you between the ages 2-18 and currently on aspirin therapy? ☐ yes ☐ no
3. Do you have a chronic medical condition including asthma or recurrent wheezing in children 2-4 years of age? ☐ yes ☐ no
4. Are you immunocompromised for any reason or caring for someone who is? ☐ yes ☐ no
5. Are you taking any antiviral medications? ☐ yes ☐ no
6. Have you had any live virus vaccines such as MMR, VAR, Shingles or Yellow Fever in the past 4 weeks? ☐ yes ☐ no

Complete this section ONLY for children 6 months through 8 years of age:

Did the child receive at least 2 doses of seasonal flu vaccine before July 1, 2020? ☐ YES ☐ NO ☐ NOT SURE

*I have been given, read or had explained to me the "INFLUENZA (FLU) VACCINE: WHAT YOU NEED TO KNOW" Vaccine Info Sheet (**August 15, 2019**). I understand the benefits and risks of influenza vaccine. I have had my questions answered. I understand there is a cost involved with receiving the influenza vaccine and that I may be responsible for a copay and/or receive a bill for the remaining amount due. I am providing accurate, complete payment information so that Public Health can bill and be reimbursed for the administration and cost of the vaccine, as applicable.*

Signature of person to receive vaccine or person authorized to make the request:

X **Date:**

THIS SECTION FOR CLINIC USE ONLY ~ Please do not write below.

☐ **PRIVATE SUPPLY**

MNVFC
☐ **On MA/PMAP** ☐ **Uninsured**
☐ **American Indian/Alaskan**

UUAV
☐ **Uninsured** ☐ **Out of pocket vaccine cost**
☐ **Other- no screening required - Flu**

Dose: ☐ 0.20 mL (nasal) ☐ 0.50 mL IM (quad) ☐ 0.70 mL IM (high dose)	Site of Vaccination: ☐ Right Deltoid ☐ Right Vastus ☐ Nasal ☐ Left Deltoid ☐ Left Vastus	Nurse's Signature:

Clinic ID:	Date Vaccinated:	Manuf.	Lot #	Exp: