ARKANSAS DEPARTMENT OF HEALTH
2014-2015 INFLUENZA SEASON -- IMMUNIZATION CONSENT FORM

For ADH use only ADH Clinic Code: ________________ Date Of Service: _____________

School Name: ____ School Grade: __________ (If school clinic)

Person Receiving Vaccine:

(Legal) First Name: ______________________________ **MI** ____ **Last** ______________________________________

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.

	YES	NO	
Have you ever had a serious allergic reaction to eggs? If yes, as a precaution, it is recommended you do not receive the flu vaccine until you have consulted your private healthcare provider.			If any answer is YES, you may not be able to receive the flu vaccine.
Have you ever had a serious reaction to a previous dose of flu vaccine?			
Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?			
Are you younger than 2 years? ☐ Yes ☐ No Are you older than 49 years? ☐ Yes ☐ No			If any answer is YES, you can receive only the <u>injectable</u> flu vaccine (shot), not the intranasal flu vaccine (flu mist).
Are you pregnant? If yes, what is the date of your last menstrual period? ☐☐ / ☐☐ / ☐☐			
Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?			
Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?			
Have you received any of these vaccines in the last 28 days? Measles, mumps, rubella (MMR) ☐ Yes ☐ No Varicella (chickenpox) ☐ Yes ☐ No Intranasal influenza vaccine (Flu Mist) ☐ Yes ☐ No			
Do you have a severely weakened immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?			
Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?			
For parents NOT attending flu clinic with their child: If you answered No to all of the above questions, your child may receive either the flu shot (injectable) or flu mist (nasal spray). In school-aged children, flu mist seems to provide greater protection. Please mark your preference of vaccine type below. **If your preferred vaccine type is not available or marked, the nurse will give what is available unless you indicate otherwise**. ☐ **Flu Shot** ☐ **Flu Mist** ☐ **No Preference** ☐ **Do not give if my preference is not available** **Child's Homeroom Teacher:** ____ **(For school clinic use)**			

2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form**.** The Arkansas Department of Health's Privacy Notice is on the website www.healthy.arkansas.gov, posted and available at the clinic site, or accompanies this form.
Then sign on the first line in the box at right.

Please sign here

My signature below indicates I have read, understand and agree to section **2. Release and Assignment** of the 2014-2015 Influenza Season -- Immunization Consent Form. Consent valid through June 30, 2015.

Signature of Patient/Parent/Guardian:

____________________________date_____________

Signature and Title of Vaccine Administrator:

____________________________date ____________

2. RELEASE AND ASSIGNMENT:

I have read or had explained to me the 2014-2015 Vaccine Information Statements for the Inactivated Influenza Vaccine and the Live Attenuated Intranasal Vaccine (Flu Mist) dated 08/19/2014, and understand the risks and benefits.

I give consent to the State/Local Health Department and its staff for the individual named below to be vaccinated with the flu vaccine.

I hereby acknowledge that I have reviewed a copy of the Arkansas Department of Health's Privacy Notice.

I understand that information about this flu vaccination will be included in the Arkansas Department of Health's Immunization Registry.

To My Insurance Carrier(s):

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
- **I authorize and request payment of medical benefits directly to the Arkansas Department of Health.**
- **I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.**
- **I agree that the photocopy of this form may be used instead of the original.**

3. PATIENT INFORMATION:

(Legal) First Name: ___________________________ **MI** ____ **Last Name**___________________________________

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Gender**: ☐ Male ☐ Female **Phone #:** ________________________

Street Address **(No PO Box):** ____ **Apt. No.** ____________

City: ____ **State:** ____________ **Zip Code:** ☐☐☐☐☐

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African-American ☐ American Indian/Alaska Native

☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other

4. INSURANCE STATUS (Check appropriate box):

Patient's Relationship to Insurance Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

☐ **Medicaid/ARKids Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Medicare Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Insurance Company Name**: ____

Member ID/Policy #: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

POLICY HOLDER Information (if other than patient):

(Legal) First Name: _____________________________ **MI** ____ **Last Name:** ________________________________

Policy Holder Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

Policy Holder's Employer Name: ____

Flu Vaccine Administration (Completed by ADH staff only)

SHOT CODE:

☐ 48: Quadrivalent (P-F) 6- 35 months
☐ 39: Quadrivalent Intranasal vaccine (P-F) 2 through 49 years
☐ 44: Quadrivalent (P-F) $\geq$ 3 years

Site Codes: Right Arm = RA, Right Leg = RL, Left Arm = LA, Left Leg = LL

2014 Flu Vaccine	Route	Site Code	Dosage mL.	Dose Number (1st or 2nd)	MFG Code	Lot Number	Is a 2nd dose needed?	
	☐ IM ☐ Intranasal						**YES**	**NO**

Date Vaccine Administered: _________/_________/_________

Revised 08/14