ARKANSAS DEPARTMENT OF HEALTH
2012-2013 INFLUENZA SEASON -- IMMUNIZATION CONSENT FORM

For ADH use only ADH Clinic Code:_____ School INC PIN_____ School Grade _____ DOS: _____

There are two forms of flu vaccine, injectable and intranasal mist. Both forms of vaccine are equally effective. See the Vaccine Information Statements for specific information.

NAME of Person Receiving Vaccine: _____ 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 cannot 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 or older than 49 years?			If any answer is yes, you can receive only the injectable flu vaccine (shot), not the intranasal flu vaccine (flu mist).
Are you pregnant?			
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). 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:** _____			

Please read the section **2. Release and Assignment** 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 2012-2013 Influenza Season -- Immunization Consent Form. Consent valid through June 30, 2013.

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 2012-2013 Vaccine Information Statements for the Inactivated Influenza Vaccine and the Live Attenuated Intranasal Vaccine (Flu Mist) dated 7/02/12, 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: First Name: _____ MI _____ Last Name_____

Date of Birth: ____/_____/_____ Gender: ☐Male ☐Female **Phone Number** _____

Address: _____ **Apt. No.** _____

City: _____ State: _____ **Zip Code: _____**

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

☐Asian ☐Native Hawaiian/Other Pacific Islander ☐Other

Patient Status (check all that apply): ☐ **Employed** ☐**Full Time Student** ☐**Part Time Student** ☐**Other**

4. INSURANCE STATUS (Check appropriate box)**:**

☐ **No Insurance** ☐ **Underinsured** (insurance does not pay full amount for vaccine)

☐ **Medicaid/ARKids Number:** _____

☐ **Medicare Number** _____ (List Supplemental Plan Below)

☐ **Insurance Company Name** (**primary**): _____

Member ID/Policy #: _____ Group Number: _____

Subscriber's Last Name: _____ Subscriber's First Name: _____

Subscriber's Date of Birth: _____ Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

Subscriber's Employer Name: _____

☐ **Insurance Company Name** (**secondary**): _____

Member ID/Policy #: _____ Group Number: _____

Subscriber's Last Name: _____ Subscriber's First Name: _____

Subscriber's Date of Birth: _____ Patient's Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

5. Flu Vaccine Administration (Completed by ADH staff only)

SHOT CODE:

☐ 48: Preservative Free (P-F) 6- 35 months

☐ 59: Preservative Free (P-F) ≥ 3 years

☐ 39: Intranasal vaccine. Preservative Free (P-F) 2 through 49 years

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

2012 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: _____/_____/_____

Imm-Flu Rev 07/2012