

(Listed

Below)

(Place Appropriate Sticker Below)

## 2018 Adult Influenza Vaccine Consent Form

## **Bartow County Health Department**

Please complete the following In NAME (Last)	(First)		1.1.)		EMPLOYER:				
To title (2005)	(11130)	(	,		EIIII EOTEIN				
DATE OF BIRTH (mm/dd/yyyy) GENDER: (Please Circle)			Please provide the insurance in	formation & at	tach a				
	Male / Female				copy of the insurance card to this form.				
ETHNICITY (Please Circle)	RACE (Please Cir								
Not Hispanic/Latino Hispanic Latino	White Black/African American Asian American Indian/ Alaskan Native Hawaiian or Polynesian Multicultural				Policy Holder Name				
HOME ADDRESS	DDRESS					Policy Holder DOB			
CITY STA	TE			ZIP CODE					
					Group#				
INSURANCE INFORMATION: Please check health insurance provider below:  Aetna Medicare  Blue Cross Blue Shield Medicare Other (Please specify)  Member ID #									
☐ Cigna ☐ United Healthcare									
Self Pay \$35.00									
Medical Information: The followin		ll help us to d	determin	ne if you can r	eceive the influenza vaccine.				
Please circle Yes or No for each question.		2 ((				* \/	NI -		
<ol> <li>Have you ever had a serious reaction to eggs? (If yes, you cannot get the flu shot.)</li> <li>Have you ever had a serious reaction to any influenza vaccine? (If yes, you cannot get the flu</li> </ol>						* Yes	No		
shot.)						* Yes	No		
3. Have you ever had ever had Guillain-Barre Syndrome (GBS)? (A disease that causes paralysis)							No		
(If yes, you should never get the flu shot.)  4. Do you have any significant or chronic (long term) health conditions? (For example:						Yes	No		
diabetes, sickle cell disease, hear nerve disorders, HIV, cancer or a chronic health conditions receive	t conditions, weakened im	lung condition	ons, sei	zure disorde	rs, cerebral palsy, muscle or	103	140		
5. For Females, could you be pregnant? (It is recommended you receive a flu shot.)							No		
By signing below, <b>I GIVE MY CONSENT</b> medical information provided above is co 770-607-6241 or 770-383-7368. I have rof Privacy Practices on the school webs participation and receipt of the influenzal injectable influenza vaccine (flu shot).	rrect. I have he viewed the vite or at the sc	ad a chance t accine Infort chool. I unde	to ask qu mation s erstand t	uestions which Statement fo he benefits an	were answered to my satisfaction r the Influenza Vaccine, dated 08 d risks of the influenza vaccine. I	n. Questions 3/07/15, and understand th	please cal the Notic nat		
Signature:				<i>D</i>	Oate:				
		EOR CI	IINICI	JSE ONLY					
VIS Date Mfg Lot# & Expi	iration Date:	IONCI		tivated	Date Entered into M&M:	Entry Clerk's	Initial·		

Influenza Vaccine Quadrivalent (IIV<sub>4</sub>)

		Adm Route: IM		
	Place Sticker HERE	(Circle Site) Right Deltoid	Signature of Nurse:	
8/7/15	Place Sucker HEKE	Left Deltoid	Date:	