HODGEMAN COUNTY HEALTH DEPARTMENT
INFLUENZA VACCINE CONSENT FORM

PATIENT INFORMATION

Legal Name ____ Age _____ Date of Birth___________
(Last) (First) (MI) (MUST BE 6 MO OR OLDER)

Previous / Maiden Name (if applicable) ____

Mailing Address ___________________________ City ________________ State ______ Zip Code _______

Phone Number ___________________________ Gender: ☐ Male ☐ Female SS# ____________________

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown/Declined

Race ☐ White ☐ Black or African American ☐ Asian, American Indian or Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown/Declined

Med Allergies:____

I have been offered a copy of the VIS and notice of privacy practice. I read or had explained to me the Vaccination Information Statement about influenza vaccine, and I understand the benefits and risks of influenza vaccination. I request that the influenza vaccine be given to me (or the person named above for whom I am authorized to make this request). I am aware that I am responsible to provide insurance information and if my insurance does not pay for this vaccination, I am responsible for payment.

Recipient/Parent/Guardian Signature ______________________________________ Date _______________

Name (print clearly) ______________________________________ Relationship to Client _______________

Primary Insurance Company (please provide card for copy) ______________________________________

Policy Holder Name ____ Policy Holder DOB _____________

1.	Is the person to be vaccinated sick today?	Yes	No
2.	Does the person to be vaccinated have an allergy to eggs or an ingredient of the vaccine?	Yes	No
3.	Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	Yes	No
4.	Has the person to be vaccinated ever had Guillain-Barré syndrome?	Yes	No

FOR OFFICE USE ONLY

140 Fluzone Private VFC 317	**111 FluMist Private VFC**	**155 Flublok**	**135 High Dose**
6 mo + 0.5 mL 90656+90471	**2-49 yr 0.2 mL 90660+90473**	**18 yr + 0.5 mL 90673+90471**	**65 yr + 0.7 mL 90662+G0008**
SITE: RT LT Deltoid Vastus Lat	**SITE: Oral Nasal**	**SITE: RT LT Deltoid**	**SITE: RT LT Deltoid**
VIS: 01/31/2025	**VIS: 01/31/2025**	**VIS: 01/31/2025**	**VIS: 01/31/2025**
Lot #/Exp/Manufacturer: (LABEL)	**Lot #/Exp/Manufacturer:** (LABEL)	**Lot #/Exp/Manufacturer:** (LABEL)	**Lot #/Exp/Manufacturer:** (LABEL)

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Vaccine Administrator Signature Date