## Ray County Health Department

## Ray County health deapartment 820 E. Lexington Street Richmond, MO 64085

## Influenza consent form

|  |  |  |
| --- | --- | --- |
| **Last Name:** | **First Name:** | **Middle:** |
| **Street Address:** | **City:** | **Patient Birth Date:**  **/ /** |
| **State:** | **Zip Code:** | **Phone Number:** |
| **Do you have a history of GBS?** **□Yes □No** | **Are you sick today? □ Yes □ No**  | **Pregnant more than 3 Months? □Yes □No** |
| **Have you had a severe reaction to a vaccine in the past? □ Yes □ No** | **Do you have any severe allergies? □Yes □No** | **List of allergies:** |
| **Private Insurance Name:** | **Group #:** | **Policy #:** |
| **Medicare #:** | **Medicaid #:** | **Self Pay: $** |

 “I have read or have had explained to me the information on the Influenza Information Statement form (08/06/2021) about influenza and influenza vaccine. I acknowledge that this vaccination record will be kept in my medical file. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me, or the person named below for whom I am authorized to make this request.”

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Initials of Administrator/Title:** | **Lot #:** | **Date:** | **Site: □ Left Deltoid**  **□ Right Deltoid**  |

## Ray County health deapartment 820 E. Lexington Street Richmond, MO 64085

## Influenza consent form

|  |  |  |
| --- | --- | --- |
| **Last Name:** | **First Name:** | **Middle:** |
| **Street Address:** | **City:** | **Patient Birth Date:**  **/ /** |
| **State:** | **Zip Code:** | **Phone Number:** |
| **Do you have a history of GBS?** **□Yes □No** | **Are you sick today? □ Yes □ No**  | **Pregnant more than 3 Months? □Yes □No** |
| **Have you had a severe reaction to a vaccine in the past? □ Yes □ No** | **Do you have any severe allergies? □Yes □No** | **List of allergies:** |
| **Private Insurance Name:** | **Group #:** | **Policy #:** |
| **Medicare #:** | **Medicaid #:** | **Self Pay: $** |

 “I have read or have had explained to me the information on the Influenza Information Statement form (08/06/2021) about influenza and influenza vaccine. I acknowledge that this vaccination record will be kept in my medical file. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me, or the person named below for whom I am authorized to make this request.”

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Initials of Administrator/Title:** | **Lot #:** | **Date:** | **Site: □ Left Deltoid**  **□ Right Deltoid**  |