Flu Consent 2021/2022

Patient Name:_____ Date of Birth:_____ Male/Female

Address:_____

Phone:_____ Email:_____

Policy Holder:_____ Policy Holder's DOB:_____

Insurance/Medicaid/Medicare ID# & Group#:_____

I have been given a copy and have read or had explained to me the information contained in the Vaccine Information Statement about the disease and vaccine. I understand the benefits and the risks of the vaccine and request that the vaccine be given to me or the person for whom I am authorized to make the request. I agree that this information may be shared with schools, day care centers, health care providers and others when medically necessary. I authorize Medicaid/Medicare or my private insurance benefits to be paid to TriCounty Health Department or it's authorized agent and for TriCounty Health Department and its authorized agent to release information to Medicaid/Medicare or my private insurance as necessary to process claims.

I understand that it is my FINANCIAL RESPONSIBILITY and I will be LIABLE for any or all remaining balance not paid by my insurance.

Client, Parent or Guardian Signature:_____

Printed Name:_____ Date:_____

Please circle any that apply to person receiving vaccine:

History of Guillain-Barré Syndrome | Egg Allergy | 65 yrs +

VFC	PVT

----------**For Nurse Use Only**----------

Vaccine USIIS/CVX #	Product & Info	Lot # & Expiration	CPT Billing Code	Dose in mls	Injection Site
⬜ **PVT**			90471 90472	0.5	IM Deltoid or Anterior thigh R / L
⬜ **VFC**			90471 SL 90472 SL	0.5	IM Deltoid or Anterior thigh R / L

Nurse Signature:_____ Date:_____