CASPER-NATRONA
COUNTY HEALTH DEPARTMENT

65+ HIGH-DOSE INFLUENZA VACCINE CONSENT & ADMINISTRATION FORM

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: ___ WY Resident: Yes or No

Mailing Address: _____ City/State/ZipCode: _____

Primary Phone #: _____ Date of Birth: _____ Age: _____

Gender Identity: ☐Male ☐Female ☐Other _____

EMPLOYER RESPONSIBILITY: Yes or No If "Yes", Employer Name: _____

INSURANCE STATUS: ☐ Uninsured ☐ Underinsured ☐ Insured (billing insurance)

☐ Insured (choosing not to bill; paying out of pocket) ☐ Medicaid ☐ Medicare Part B

Complete the following if billing insurance

Medicare#: _____ Medicaid#: _____

Insurance Name:_____ **Insurance Number:**_____

Group Number: _____ **Policy Holder Name:**_____

Policy Holder Date of Birth:_____ **Policy Holder Address:** _____

SCREENING QUESTIONAIRE

Have you received flu vaccine before? ..... Yes or No

Did you have any problems with previous flu vaccine? ..... Yes or No

Do you have a fever today? ..... Yes or No

Do you have a history of Guillain-Barre Syndrome (a paralysis problem)? ..... Yes or No

I have been offered the Vaccine Information Statement about the vaccine(s) to be given today. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to me or the patient named above for whom I am authorized to make this request as their legal guardian.

The Notice of Privacy Practices describes how CNCHD may use or disclose information. Not all situations may be described. CNCHD is required to offer its clients a Notice of Privacy Practices pertaining to information we use, maintain, and disclose. I have been presented with a copy of the CNCHD Notice of Privacy Practices. I have had the chance to ask questions that were answered to my satisfaction about how my information will be used.

I, HEREBY, ATTEST THAT THE INFORMATION GIVEN ABOVE IS ACCURATE/TRUE, AND I AGREE TO THE TERMS AND CONDITIONS AS SET FORTH ABOVE.

_____ _____

Signature of Patient *(Print & Sign if Legal Representative other than patient)* Date of Signature

FOR STAFF USE ONLY

Date Vaccine Administered:_____ Clinic Site: _____ VIS Date: 08/15/2019

Immunization Injection Site: ☐RD ☐LD Dose: 0.5 ML Vaccine Lot #

Nurse's Signature: _____ WYIR Entered: _____

Patagonia Entered: _____

PAYMENT TYPE: Cash or Check #_____ Amount Received: $_____

Revised: 9/17/2020