HIGH DOSE FLU CONSENT

PAID: CASH/CHK_____

CASPER-NATRONA
COUNTY HEALTH DEPARTMENT

INFLUENZA VACCINE
CONSENT & ADMINISTRATION FORM

DATE:

PATIENT INFORMATION

Last Name: _____ First Name: _____ Date of Birth: _____/_____/_____ Age: _____

Physical Address: _____

City/State/Zip: _____ County _____

Phone: _____ Gender Identity: ☐ Male ☐ Female ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other: _____

Race:
- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Other: _____

Insurance Status: ☐ Uninsured ☐ Underinsured ☐ Insured (Billing Insurance)
☐ Insured (Choosing Not to Bill; Paying Out of Pocket) ☐ Medicaid ☐ Medicare Part B

SCREENING QUESTIONNAIRE

Have you received flu vaccine before?	☐ Yes	☐ No
Did you have any problems with previous flu vaccine?	☐ Yes	☐ No
Do you have a fever today?	☐ Yes	☐ No
Do you have a history of Guillain-Barre Syndrome (a paralysis problem)?	☐ Yes	☐ No
Is the person to be vaccinated 65 years of age or older and requesting a high-dose vaccine?	☐ Yes	☐ No

Comments: _____

COMPLETE THE FOLLOWING TO BILL INSURANCE

Primary Carrier Insurance Company: _____

Insurance Carrier Mailing Address, City/State/Zip: _____

Policy Holder's Name _____ Policy Holder DOB: _____/_____/_____ Policy Holder's Sex: _____

Employer of Policy Holder _____

Policy #: _____ Group #: _____

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*

TO BE COMPLETED BY CNCHD STAFF ONLY

Date Vaccine Administered: _____ Clinic Site: _____ VIS Date:

VFC Eligible: ☐ Yes ☐ No Immunization Injection Site: ☐ R. Deltoid ☐ L. Deltoid ☐ R. Thigh ☐ L. Thigh

Lot #: _____ ☐ High Dose Flu

_____ _____ _____

Nurse's Signature *WYIR Entered* *CureMD Entered*

CASPER-NATRONA
COUNTY HEALTH DEPARTMENT

COVID-19 VACCINE
CONSENT & ADMINISTRATION FORM

SCREENING QUESTIONNAIRE

Has the person to be vaccinated ever received a COVID-19 vaccine?. . . . . ☐ No ☐ Yes

If yes, date/s: _____ Type/Brand of vaccine: _____

Does the person to be vaccinated have an allergy to any medications, foods, vaccines, or latex?. . . . . ☐ No ☐ Yes

List all allergies: _____

Has the person to be vaccinated ever had a severe reaction to any vaccine or injectable therapy? . . . . . ☐ No ☐ Yes

Is the person to be vaccinated sick today? . . . . . ☐ No ☐ Yes

Is the person to be vaccinated at least 18 years old? . . . . . ☐ No ☐ Yes

If no, is the person to be vaccinated at least 12 years old? . . . . . ☐ No ☐ Yes

Does the person to be vaccinated have a bleeding disorder or are they taking a blood thinner? . . . . . ☐ No ☐ Yes

Has the person to be vaccinated received passive antibody therapy as treatment for COVID-19? . . . . . ☐ No ☐ Yes

Does the person to be vaccinated attest to having any of the following (see below). . . . . ☐ No ☐ Yes

Organ/stem cell transplant? . . . . . ☐ No ☐ Yes

Work/live in high risk setting? . . . . . ☐ No ☐ Yes

On immunosuppressant/high dose steroids? ☐ No ☐ Yes

Moderate/severe immunodeficiency? . . . . . ☐ No ☐ Yes

Active cancer treatment? . . . . . ☐ No ☐ Yes

WHICH COVID VACCINE ARE YOU WANTING TODAY(Please Circle): MODERNA / PFIZER

Has it been 2 months or longer since your last Covid vaccine? Yes/ No

I have been offered a copy of the Emergency Use Authorization (EUA) Fact Sheet for the COVID-19 vaccine. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the patient named above for whom I am authorized to make this request as their legal guardian.

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES FOR OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

_____ _____

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

VACCINE ADMINISTRATION DOCUMENTATION - TO BE COMPLETED BY CLINIC STAFF ONLY

Date Vaccine Administered: _____ Time: _____ Site/Route: ☐ LA/RA ☐ IM

Vaccine Lot #: _____

Dose (Moderna Only): ☐ .5mL ☐ .25mL

Pfizer ☐ .3mL

_____ _____ _____ _____

Nurse's Signature *CureMD Entered* *WYIR Entry Complete* *ESB Complete*