Delaware General Health District
Flu Vaccine Consent Form

PLEASE PRINT CLEARLY

First Name: ______________________ Middle Initial: ___

Last Name: ______________________ Gender: ___

Address: ______________________

City: ______________________ State: ____ Zip: ______

Phone: ___ - ___ - ____ Home Cell Work (please circle one)

Birthdate: M M / D D / Y Y Y Y Age: ___

Email:___________________________________ **Race:**________________ **Preferred Language:** ________________

Ethnicity (please circle one): Hispanic/Latino Not Hispanic/Latino

PRIMARY Insurance Company: _______________________**Member ID:**_____________________________**Group#**___________

Claim Submission Address (back of insurance card)____

Primary Insured Info: Name:____**Birthdate**____________________

Relationship to Patient________________________ **Social Security Number:**____

Address of Primary Insured (*if different from patient*):____

SECONDARY Insurance Company: ______________________Member ID:_____________________________Group______________

Claims Submission Address (back of insurance card) ____

Primary Insured Info: Name:____Birthdate____________________

Relationship to Patient__________________________Social Security Number: ____

Address of Primary Insured (*if different from patient*):____

IF NO INSURANCE, PLEASE COMPLETE THE FOLLOWING TO REQUEST DISCOUNTED SERVICES:

"I state that there are ________ number of people living in my household

and the combined household income is $_____________ per week / month / year" (circle one)

Please answer the following questions:	
1. Are you sick today?	Yes___ No___
2. Are you allergic to eggs? (Can't eat eggs)	Yes___ No___
3. Are you allergic to any vaccine components? If yes, what component? _____________________	Yes___ No___
4. Have you ever had a serious reaction after receiving a vaccination?	Yes___ No___
5. Have you ever had a paralyzing illness (Guillain Barre Syndrome)?	Yes___ No___
6. For children under 9 years of age, since 2010, has your child received 2 flu vaccines?	Yes___ No___
7. Do you have AIDS, HIV, Cancer, or have you received an organ transplant, or taking medication that lowers the body's resistance to infection?	Yes___ No___

The doctor or clinic may keep this record in your medical file. They will record what vaccine was given, date the vaccine was given, the name of the company that made the vaccine, the vaccine special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. I understand that this information will be released to a state-wide Immunization Registry for the purpose of immunization tracking recall and recording, unless I request otherwise. I have read or have had explained to me the information sheet about influenza disease and the influenza vaccine. I have had a chance to ask question, and they were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to the person named above for whom I am authorized to make this request. Your medical information is never shared without an authorization to release information. A copy of the Health Districts Notice of Privacy Practices (HIPAA) will be provided upon request, and it is also located on our website at www.delawarehealth.org. I authorize my insurance company to assign the amount payable directly to DGHD. I understand that I am financially responsible for all the charges that are not covered under my private insurance plan. I acknowledge that any co-payment is due and payable on the date services are received.

Parent/Guardian Name (please print clearly):_____________________________________Parent/Guardian DOB:_______________

Relationship to Patient:______________________________

Parent/Guardian/Patient Signature: ____ Date: ____________________

STOP — AREA BELOW FOR OFFICE USE ONLY

INFLUENZA	INJECTION SITE	VACCINE MANUFACTURER	NURSE SIGNATURE
PRIVATE STATE VFC ☐ NN ☐ IMPACT	RD RVL LD LVL IM INTRANASAL PRES. FREE W/ PRES.	GSK SP MED LOT #________________________ Quadrivalent EXP: 6/30/19 EXP:____________	Date:________________________ _________________________, RN

NOTES:____

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