**TWO RIVERS PUBLIC HEALTH DEPARMENT INFLUENZA CONSENT FORM**

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|  **STUDENT/STAFF MEMBER INFORMATION** |
|  SCHOOL  | GRADE | TEACHER |
| LAST NAME | FIRST NAME | MI | MAIDEN NAME (IF APPLICABLE) |
| DATE OF BIRTH\_ \_ / \_ \_ / \_ \_ \_ \_ | AGE | SEXM F | MOTHER’S MAIDEN NAME (FIRST AND LAST) | PHONE( ) |
| STREET ADDRESS | P.O.BOX (IF APPLICABLE) | CITY | STATE | ZIP |
| **INSURANCE INFORMATION** |
| RELATIONSHIP OF STUDENT/STAFF TO INSURANCE SUBSCRIBER □ SELF □ SPOUSE □ CHILD □ OTHER | INSURANCE PROVIDER * BLUE CROSS BLUE SHIELD (MUSTHAVEPHOTO/COPY OF CARD)
* UNITED HEALTH CARE
* MEDICAID: **CIRCLE ONE**

 *UHC NTC WELLCARE** MEDICARE (SS# REQUIRED)
* OTHER: \_
* None
 |
| SUBSCRIBER NAME (IF DIFFERENT THAN ABOVE) | SUBSCRIBER BIRTH DATE\_ \_ / \_ \_ / \_ \_ \_ \_ | SOCIAL SECURITY # |
| STREET ADDRESS (IF DIFFERENT THAN ABOVE) | CITY | STATE | ZIP |
| PHOTO OF CARD (FRONT & BACK) □ DRCHRONO □ PHOTO COPY ATTACHED □ STAFF DEVICE (DEVICE # ) |
| **SCREENING QUESTIONNAIRE- Questions must be completed before vaccine is administered** |
|  | **YES** | **NO** | **DON’T KNOW** |
| DO YOU HAVE ALLERGIES TO EGGS OR A VACCINE COMPONENT? |  |  |  |
| HAVE YOU EVER HAD DIFFICULTY BREATHING AFTER RECEIVING A VACCINATION? |  |  |  |
| HAVE YOU HAD A SEIZURE, BRAIN/NERVOUS SYSTEM DISORDER OR GUILLAIN-BARRE?**I GIVE CONSENT** to the **Two Rivers Public Health Department** and its staff to vaccinate the person listed on this form. I have read or had explained to me theVaccine Information Statement and understand the risks and benefits. I hereby grant permission to Two Rivers Public Health Department to release any pertinent information to the above insurance company upon request and any physicians to whom I might be referred. I understand that if my child is uncooperative or resistant, I will be notified by Two Rivers Public Health Department if vaccine was NOT able to be administered.**Authorized Signature (*client, if 19 or older, or parent/legal guardian)***Today’s Date: *(month/day/year)* |  |  |  |

 **X**

Seqirus

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **VACCINE****\*\*Child will not be seen without a complete form, parent signature, and copy of insurance\*\*** | **FORM** | **AGE** | **MAN/LOT/EXP** | **SITE** | **NURSE/DATE** |
|  Sanofi | Fluzone PREFILLED | 6 mo+ |  | LA RA |  |
|  |  |  | LA RA |  |
|  |  |  | LA RA |  |
|   GSK | FluLaval PFS | 6 mo+ |  | LA RA |  |
|  |   |  | LA RA |  |
|  |  |  | LA RA |  |
| VFC |  |  |  |  LA RA |  |
|  |  |  |  LA RA |  |
| FLuad HD | 65+ |  |  LA RA |  |

TRPHD STAFF ONLY - VACCINE RECIPIENT'S TEMPERATURE TODAY:

Dr. Chrono / NESIIS / Billed / Paid Cash/Donation

 Special Note: