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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **STUDENT/STAFF MEMBER INFORMATION** | | | | | | | | | | | | | | |
| SCHOOL | | | | | GRADE | | | TEACHER | | | | | | |
| LAST NAME | | | | FIRST NAME | | | MI | | MAIDEN NAME (IF APPLICABLE) | | | | | |
| DATE OF BIRTH  \_ \_ / \_ \_ / \_ \_ \_ \_ | AGE | SEX  M 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 the  Vaccine 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: