

# CONSENT TO RECEIVE INFLUENZA VACCINE 2021 / 2022



**Public Health**  
Prevent. Promote. Protect.  
Rice County Public Health

**Rice County Public Health**  
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Last Name <i>(please print)</i>	First Name	Middle Initial	Birth Date (mo/day/year)	Age
Street Address		Phone	Male <input type="checkbox"/>	Female <input type="checkbox"/>
City	State	Zip Code		

Rice County Public Health participates in the Minnesota Immunization Information Connection (MIIC). Immunization data may be shared with MIIC, other healthcare providers, schools, and health departments directly involved in keeping you up-to-date with immunizations. Information you provide is private and is not shared with others except as needed for payment, treatment, and agency operations. A copy of Rice County Public Health Notice of Privacy Practices is available upon request and is posted on our website at: [www.co.rice.mn.us/DocumentCenter/View/821/Privacy-Practices-PDF](http://www.co.rice.mn.us/DocumentCenter/View/821/Privacy-Practices-PDF)

**Check vaccine interested in\***

- High Dose – Only for 65 yrs & older
- Quadrivalent Injectable – 6 mo. & older
- FluMist – Ages 2 yrs thru 49 yrs

\*Vaccines subject to availability & program guidelines.

**RCPH bills to Medicare, MA, Health Partners, Blue Cross, Medica**

**Payment Information Check 1<sup>st</sup> Applicable**

- Medicare B ID# \_\_\_\_\_
- Private Insurance \_\_\_\_\_
- MA, Ucare, Blue Plus, Medica \_\_\_\_\_
- Private Pay: \$40 Quadrivalent/\$80 High Dose
- Uninsured

## PLEASE COMPLETE THESE QUESTIONS:

- Are you allergic to Thimerosal, Formaldehyde or egg protein?  yes  no
- Have you ever had a systemic allergic reaction (anaphylaxis) to eggs?  yes  no
- Have you ever had a severe reaction to flu vaccine or any other immunization?  yes  no
- Have you ever had Guillain-Barre Syndrome or "French Polio?"  yes  no
- Do you have a fever, or are you ill today?  yes  no

### ADDITIONAL QUESTIONS FOR FLUMIST (AGES 2 – 49)

- Are you pregnant or is there a chance you are pregnant?  yes  no
- Are you between the ages 2-18 and currently on aspirin therapy?  yes  no
- Do you have a chronic medical condition including asthma or recurrent wheezing in children 2-4 years of age?  yes  no
- Are you immunocompromised for any reason or caring for someone who is?  yes  no
- Are you taking any antiviral medications?  yes  no
- Have you had any live virus vaccines such as MMR, VAR, Shingles or Yellow Fever in the past 4 weeks?  yes  no

**Complete this section ONLY for children 6 months through 8 years of age:**

Did the child receive 2 doses or more of seasonal flu vaccine in prior seasons?  YES  NO  NOT SURE

I have been given, read or had explained to me the "INFLUENZA (FLU) VACCINE: WHAT YOU NEED TO KNOW" Vaccine Info Sheet (08/06/21). I understand the benefits and risks of influenza vaccine. I have had my questions answered. I understand there is a cost involved with receiving the influenza vaccine and that I may be responsible for a copay and/or receive a bill for the remaining amount due. I am providing accurate, complete payment information so that Public Health can bill and be reimbursed for the administration and cost of the vaccine, as applicable.

**Signature of person to receive vaccine or person authorized to make the request:**

X

Date:

THIS SECTION FOR CLINIC USE ONLY ~ Please do not write below.

**MNVFC**

- On MA/PMAP
- Uninsured
- American Indian/Alaskan

**UUAV**

- Uninsured
- Out of pocket vaccine cost
- Other- no screening required - Flu

PRIVATE SUPPLY

Dose: <input type="checkbox"/> 0.20 mL (nasal) <input type="checkbox"/> 0.50 mL IM (quad) <input type="checkbox"/> 0.70 mL IM (high dose)	Site of Vaccination: <input type="checkbox"/> Right Deltoid <input type="checkbox"/> Right Vastus <input type="checkbox"/> Nasal <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Left Vastus	Nurse's Signature:
Clinic ID:	Date Vaccinated:	Manuf. Lot # Exp: