

INFLUENZA (IIV/RIV) VACCINE CONSENT FORM AND ADMINISTRATION RECORD 2021-2022

WyVIP/VFC Eligibility: Medicaid Uninsured Underinsured Insured Native/Alaskan American WY Resident Non-Resident

Information about person to receive vaccine (please print)

Name: _____ Birth date and age: _____ Sex: Male Female
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Doctor: _____

1. Have you received flu vaccine before?..... No Yes
2. Did you have any problems with previous flu vaccine?..... No Yes
3. Are you ill today?..... No Yes
4. Do you have allergies to eggs, latex, or to Thimerosal Mercury (a preservative)?..... No Yes
5. Do you have a history of Guillian-Barre Syndrome (a paralysis problem)?..... No Yes
6. If you are younger than 9 years of age, have you received flu vaccine before?..... No Yes
7. Have you received a pneumonia vaccine? No Yes If Yes, what year? PPSV23 _____ PCV13 _____

PAYMENT INFORMATION:

Medicare# _____ Medicaid# _____
 Other Pay Source: _____ PAID BY: CASH _____ CHECK # _____

Insurance Information					
Primary Carrier Insurance Company			Secondary Carrier Insurance Company		
Insurance Carrier Mailing Address	City	State/Zip	Insurance Carrier Mailing Address	City	State/Zip
Policy Holder's Name	Employer of Policy Holder		Policy Holder's Name	Employer of Policy Holder	
Policy Holder DOB:	Policy Holder's Sex:		Policy Holder DOB:	Policy Holder's Sex:	
Policy #	Group #		Policy #	Group #	

I have read, or have had explained to me, the Vaccine Information Statement (VIS) about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian). If qualified, I authorize billing to my insurance company or my employer. I have received and read the Wyoming Department of Health Notice of Privacy Practices and have had a chance to ask questions about how my information will be used.
I HAVE BEEN ADVISED TO PROCEED TO THE DESIGNATED PARKING AREA AFTER RECEIVING MY FLU SHOT AND WAIT FOR 15 MINUTES OF OBSERVATION BEFORE LEAVING.

Print Parent/Guardian name, if different from client: _____

Client/Parent/Guardian Signature: _____ Date: _____

FOR CLINIC USE ONLY

CLINIC SITE: _____ VIS DATE: AUGUST 6, 2021

DATE VACCINE ADMINISTERED: _____ DATE BOOSTER REQUIRED: _____

VACCINE MAN. & LOT NUMBER: _____ IIV3 IIV4 HD-IIV4 RIV4 ccIIV4
 aIIV4

SITE OF IM INJECTION: RDT OR LDT OR _____ DOSE: 0.5ML 0.25ML 0.7ML

SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR: _____

NURSE'S COMMENTS: _____ SCREENED FOR COVID-19