

**TOOELE COUNTY HEALTH DEPARTMENT
SEASONAL FLU MIST CLINIC CONSENT/ENCOUNTER FORM**



Name: _____

Address: Street _____ City _____ State _____ Zip _____

Phone: _____ Date of Birth: _____ Race: _____

Sex Male Female

Insurance Company: _____ Policy #: _____

Medicaid #: _____

The person receiving the vaccine:

| | |
|---|--|
| <p><u>Yes</u> <u>No</u></p> <p>has had a serious reaction to a vaccine in the past.</p> <p>has been paralyzed by Guillain-Barre Syndrome.</p> <p>has had immunizations in the last month.</p> <p>is diabetic or has another chronic illness: heart disease, lung disease, asthma, kidney, or liver disease, metabolic disease such as diabetes, anemia, and other blood disorders.</p> <p>has been sick in the last week, on an antibiotic or antiviral medication.</p> <p>will have contact with a person with a suppressed immune system in the next 3 weeks.</p> | <p><u>Yes</u> <u>No</u></p> <p>has a serious allergy to eggs.</p> <p>is on aspirin, chemo/radiation therapy.</p> |
|---|--|

I have been given a copy and have read, or had explained to me, the information contained in the Vaccine Information Statement about the disease and vaccine. I understand the benefits and risks of the vaccine and request that the vaccine be given to me or the person for whom I am authorized to make this request. I agree that this information may be shared with schools, daycare centers, healthcare providers and others when medically necessary.

I have been given a copy of the Tooele County Health Department's Notice of Privacy Practices and have had a chance to ask questions about how my public health information will be used.

I understand that it is my responsibility to know what my insurance plan covers and agree to pay the portion not covered by my insurance. I understand that if Tooele County Health Department does not have a contract with my insurance company, or my insurance company denies payment, I am responsible for all charges incurred.

Client/Guardian Signature: _____ Date: _____

**** Space below for Public Health Nursing Information Only****

| | | |
|---------------------------|------------------------|------------------------|
| Flu Mist Site: Intranasal | Tdap: 11-65 yrs of age | Other: _____ |
| Lot # _____ 0.5 ml | | Site: _____ |
| | Deltoid ce L ce R | Lot # _____ |
| | Lot # _____ | Amount Paid: _____ |
| 274 Flu Mist | 254 Tdap | Nurse Signature: _____ |
| | 341 Td | Provider # _____ |
| | | E _____ |