TOOELE COUNTY HEALTH DEPARTMENT
SEASONAL FLU SHOT CLINIC CONSENT/ENCOUNTER FORM

Name: _____

Address: _____
Street

_____ _____ _____
City State Zip

Phone: _____ Date of Birth: _____ Race: _____

Sex: ◯ Male ◯ Female

Insurance Company: _____ Policy #: _____

Medicare #: _____ (Must have Alpha) Medicaid #: _____

The person receiving the vaccine:

Yes	No		Yes	No	
◯	◯	is less than six months of age	◯	◯	has a serious allergy to eggs
◯	◯	has had a serious reaction to a vaccine in the past	◯	◯	has moderate or severe illness
◯	◯	has been paralyzed by Guillain-Barre Syndrome	◯	◯	is a diabetic

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****

Child 6 months to 35 months of age
Flu vaccine 0.25 ml
IM in lateral mid thigh ☐L ☐R
Lot # _____

3 yrs of age and older
Flu vaccine 0.5 ml
☐IM Deltoid ☐L ☐R
☐Lateral Midthigh ☐L ☐R
Lot # _____

Pneumovax 0.5 ml
IM Deltoid ☐L ☐R
Lot # _____

☐ 65 or > and have received a Pneumovax vaccine since they turned 65.

Tdap: 11-65 yrs of age
0.5 ml Deltoid ☐L ☐R
Lot #_____

Other: _____
Site: _____
Lot #_____

Amount Paid: _____
Nurse Signature: _____

Provider #_____

260 VFC preservative free
326 VFC <3
340 VFC >3

369 PRIVATE <3
360 PRIVATE >3
375 Pneumovax
254 Tdap
341 Td

E_____