COLE COUNTY HEALTH DEPARTMENT

FLU CONSENT OUTREACH LOCATION: Helias

Personal Information—PLEASE PRINT

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH :	AGE :	GENDER M ☐ F ☐

MAILING ADDRESS	CITY	STATE	ZIP	PHONE NUMBER:

ETHNICITY: (Circle One) Amer Ind. or Alaska Native Asian Black or African American Hispanic White Biracial Other

Insurance Information—please fill out completely

☐ NO INSURANCE ☐ Medicaid If Medicaid: plan name and # _____

PRIVATE INSURANCE :

Primary Insurance Company Name: | Member ID # | Group ID #

Relationship to the policy holder: Self ☐ Spouse ☐ Dependent ☐ (If spouse or Dependant, please fill out next line)

Policy Holder's Name: | Policy Holder's DOB (MM-DD-YYYY)

Military Insurance

For TRI CARE policy holders, need the policy holder's Social Security # →

Policy Holder's Name | Policy Holder's Relationship to Patient | Policy's Holder's Date of Birth (/ /)

CHAMP VA, need the Social Security # of the patient being immunized →

FLU SCREENING QUESTIONS:

1. Does the person to be vaccinated have a serious allergic reaction to chicken, eggs, latex, mercury, gelatin, thimerosal or other vaccine components? _____YES _____NO
2. Has the person to be vaccinated ever had Guillian Barre Syndrome or any other neurological disease? _____YES _____NO
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? _____YES _____NO

SIGNATURE OF PATIENT (OR LEGAL GUARDIAN) X DATE _____

FOR OFFICE USE ONLY

CCHD / 317 / VFC Lot #_____ Site: LD / RD

Nurse:_____ Admin Date:_____