# RICHD ADULT FLU CONSENT

FULL NAME: _____
First Name M Last Name

DATE OF BIRTH: _____ AGE: _____

**STATE EMPLOYEE ONLY**
STATE EMPLOYEE ONLY: YES_____NO_____
LAST 4 OF SS#_____

CIRCLE GENDER: MALE FEMALE

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____

CIRCLE RACE: WHITE BLACK/AFRICAN-AMERICAN ASIAN AMERICAN INDIAN OTHER: _____
CIRCLE ETHNICITY: HISPANIC/LATINO NON-HISPANIC/LATINO

CIRCLE PREFERRED LANGUAGE: ENGLISH SPANISH OTHER

AUGUSTANA PLAN PPO-Traditional or HDHP

**INSURANCE PRIMARY:** BCBSIL ID#_____ GROUP# 209958 209957
(FOUND ON MEDICAL CARD) (CIRCLE ONE)

SECONDARY:_____ ID#_____ GROUP#_____

| | | |
|---|---|---|
| **Do you have any allergies? (eggs, chicken, latex or medicines) | Circle: | YES NO |
| **Have you ever had a **REACTION** to a flu shot before: | Circle: | YES NO |
| **Do you currently have an active illness or are your taking antibiotics? | Circle: | YES NO |
| **Have you had Guillain-Barre Syndrome? | Circle: | YES NO |
| **Have you traveled outside of the US within the last 30 days? | Circle: | YES NO |
| **Have you been in contact with anyone who has traveled outside of US within the last 30 days? | Circle: | YES NO |

**If you answer "yes" to any of the above questions, please let the nurse know**

JOINT NOTICE OF PRIVACY PRACTICES GIVEN

I HAVE READ OR HAD THE INFORMATION ABOUT THE INFLUENZA VACCINE EXPLAINED TO ME. I WAS GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I UNDERSTAND THE BENEFITS AND RISKS OF THE INFLUENZA VACCINE AND REQUEST THE VACCINE BE GIVEN TO ME OR THE PERSON FOR WHOM I AM AUTHORIZED TO MAKE THIS REQUEST. I UNDERSTAND THAT THE IMMUNES GIVEN TODAY WILL BE ENTERED INTO THE STATE DATA BASE, UNLESS I DECLINE. THE LAST FOUR DIGITS OF YOUR SOCIAL SECURITY NUMBER IS SO THAT YOUR BILL WHEN SUBMITTED CAN BE READILY IDENTIFIED AND PAID.

X _____
**PRINTED NAMED**

X _____ _____
**SIGNATURE** of person receiving vaccine or parent/guardian **DATE**

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AGENCY USE ONLY PP STOCK ONLY

FLU VACCINE
SITE:_____

2020-2021
VIS GIVEN:____
8/15/2019
LOT#_____
EXP DATE:_____
FLUBLOK:_____

FLUZONE QUAD: _____
HIGH DOSE: _____

Office Use Only: **BILLING**
**Clinic Site:** _____
Payment: _____ cash/check/cc#_____
Medicare _____ Private Insurance _____ IPA Adult____
Bill Township _____
Bill County for Employee/dependent: _____
State Employee:_____

SIGNATURE OF NURSE ADMINISTERING VACCINE:_____

9/4/2020

## 4 Risks of a vaccine reaction

- Soreness, redness, and swelling where shot is given, fever, muscle aches, and headache can happen after influenza vaccine.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13), and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

## 5 What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff do not give medical advice.*

## 6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim. There is a time limit to file a claim for compensation.

## 7 How can I learn more?

- Ask your healthcare provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's **www.cdc.gov/flu**