ARKANSAS DEPARTMENT OF HEALTH
INFLUENZA SEASON -- IMMUNIZATION CONSENT FORM

For ADH use only ADH Clinic Code: _____School LEA #:_____ Date Of Service: _____
School Name: _____ School Grade: _____

Person Receiving Vaccine:

(Legal) First Name: _____ MI: ____ Last Name: _____
Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.

	YES	NO	
Have you ever had a serious reaction to a previous dose of flu vaccine, such as difficulty breathing, swelling of eyes or lips, wheezing, or immediate nausea or vomiting?			If any answer is YES, you may not be able to receive the flu vaccine.
Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?			
Are you younger than 2 years? ☐ Yes ☐ No Are you older than 49 years? ☐ Yes ☐ No			If any answer is YES, you can receive only the <u>injectable</u> flu vaccine (shot), not the intranasal flu vaccine (flu mist).
Are you pregnant?			
Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?			
Are you on long-term aspirin or aspirin-containing therapy (for example, do you take aspirin every day)?			
Have you received any of these vaccines in the last 28 days? Measles, mumps, rubella (MMR) ☐ Yes ☐ No Varicella (chickenpox) ☐ Yes ☐ No Intranasal influenza vaccine (Flu Mist) ☐ Yes ☐ No			
Do you have a severely weakened immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?			
Do you have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?			
For parents NOT attending flu clinic with their child: If you answered No to all of the above questions, your child may receive either the flu shot (injectable) or flu mist (nasal spray). Please mark your preference of vaccine type below. **If your preferred vaccine type is not available or marked, the nurse will give what is available unless you indicate otherwise**. ☐ **Flu Shot** ☐ **Flu Mist** ☐ **No Preference** ☐ **Do not give if my preference is not available** **Child's Homeroom Teacher: _____(For school clinic use)**			
• **PARENT NOTE:** If your child is 6 months through 8 years of age and this is their first dose ever of flu vaccine, a second dose is needed in 4 weeks. Contact your health care provider to receive the second dose.			

2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form**.** The Arkansas Department of Health's Privacy Notice is on the website www.healthy.arkansas.gov, posted and available at the clinic site, or accompanies this form.
Then sign in the box at right.

Please sign here

My signature below indicates I have read, understand and agree to section **2. Release and Assignment** of the Influenza Season -- Immunization Consent Form.

Signature of Patient/Parent/Guardian:

_____date_____

RELEASE AND ASSIGNMENT:

- **I have read or had explained to me the Vaccine Information Statements for the Inactivated Influenza Vaccine and the Live Attenuated Intranasal Vaccine (Flu Mist) dated 08/07/2015 and understand the risks and benefits.**
- **I give consent to the State/Local Health Department and its staff for the individual named below to be vaccinated with the flu vaccine.**
- **I hereby acknowledge that I have reviewed a copy of the Arkansas Department of Health's Privacy Notice.**
- **I understand that information about this flu vaccination will be included in the Arkansas Department of Health's Immunization Registry.**

To My Insurance Carrier(s):

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
- **I authorize and request payment of medical benefits directly to the Arkansas Department of Health.**
- **I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.**
- **I agree that the photocopy of this form may be used instead of the original.**

3. PATIENT INFORMATION:

(Legal) First Name: _____ MI: ____ Last Name: _____

Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐ **Gender**: ☐ Male ☐ Female **Phone #: _____**

Street Address:_____ P.O Box _____ Apt. No. _____

City: _____ State: _____ Zip Code: ☐☐☐☐☐

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African-American ☐ American Indian/Alaska Native
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other

4. INSURANCE STATUS (Check appropriate box):

Patient's Relationship to Insurance Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

☐ **Medicaid/ARKids Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Medicare Number:** ☐☐☐☐☐☐☐☐☐☐☐

☐ **Insurance Company Name**: _____

Member ID/Policy #: ☐☐☐☐☐☐☐☐☐☐☐☐☐

REQUIRED POLICY HOLDER Information:

(Legal) First Name: _____ MI: ____ Last Name: _____

Policy Holder Date of Birth: ☐☐ / ☐☐ / ☐☐☐☐

Policy Holder's Employer Name: _____

Flu Vaccine Administration (Completed by ADH staff only)

SHOT CODE:

☐ 70: Quadrivalent (P-F) ≥6 months
☐ 44: Quadrivalent (P-F) ≥ 3 years
☐ 39: Quadrivalent Intranasal vaccine (P-F) 2 - 49 years
☐ 48: Quadrivalent (P-F) 6 - 35 months

	Route	Site Code	Dosage mL.	MFG Code	Lot Number
Flu Vaccine	☐ IM ☐ Intranasal				

Site Codes: Right Arm = RA, Right Leg = RL, Left Arm = LA, Left Leg = LL

Signature and Title of Vaccine Administrator: _____

Date Vaccine Administered: _____/_____/_____

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