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: ☐☐ / ☐☐ / ☐☐☐☐ Age: ____ **(ADH Employee Receiving Vaccine Only) AASIS#:_____**

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

If YES and further guidance is needed, notify the Regional CDNS	***YES**	**NO**	
Do you have a fever today? (If you have a fever on the day of the clinic it may prevent you from receiving the influenza vaccine.)			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?			
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? Do you have a severe allergy to any flu vaccine component, or to any food, or medication? (i.e., gelatin, gentamicin, or neomycin)			
NOTE: Children aged 6 months through 8 years may require a second dose. Contact your health care provider or your ADH Local Health Unit in four weeks for more information.			
For school clinic use: Child's Homeroom Teacher: _____			

2. RELEASE AND ASSIGNMENT:

- **I have read or had explained to me the Vaccine Information Statements for the Inactivated Influenza Vaccine and I understand the risks and benefits. To read the Vaccine Information Statement (VIS) for each vaccine visit the website to view current VIS: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html**
- **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.**

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 and **Vaccine Information Statement (VIS).**

Signature of Patient/Parent/Guardian:

_____date_____

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: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

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: ☐☐ /☐☐ /☐☐☐☐ **Email Address: _____**

Policy Holder's Employer Name: _____

Flu Vaccine Administration (Completed by ADH staff only)

SHOT CODE:

☐ 70: Quadrivalent (P-F) ≥ 6 months ☐ 72:Quadrivalent (P-F) ≥ 65 years

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

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

MFG Codes: SKB = GlaxoSmithKline, PMC = Sanofi, MED = MedImmune, SEQ = Seqirus

Signature and Title of Vaccine Administrator: _____

Date Vaccine Administered: _____/_____/_____

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