

Date: \_\_\_\_\_

Chart #: \_\_\_\_\_

# Marquette County Health Department Seasonal Influenza Vaccine Program Adult Form (19 years old and above)

Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

## FLU MIST IS NOT AVAILABLE THIS FLU SEASON

Sex:  Male  Female      Marital Status:  Single  Married  Divorced  Widowed

**Race:**

White  Asian  Black/African American  Native Alaskan/American Indian  Native Hawaiian/Pacific Islander

**Ethnicity:**  Hispanic/Latino  Non-Hispanic/Latino

**Are you enrolled in any of the following?: (Please present your insurance card to registration)**

Medicaid  Medicare Part B  No Medical Insurance  Cash/Check/Credit  Insurance

Card Holder Name: \_\_\_\_\_ Card Holder Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Medical Screening Questionnaire & Consent for Vaccination

YES	NO	
		1. Have you ever had a serious reaction to a vaccine?
		2. Are you allergic to eggs or any antibiotics?
		3. Have you ever had Guillain-Barre syndrome (GBS)?
		4. Are you currently ill or running a fever?

**"I have read or have had explained to me the information in the vaccine information statement (VIS). I have also had a chance to ask any questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine." (Initial here)**

**Marquette County Health Department has made their Privacy Act practices available to me. (Initial here)**

**"I authorize the release of any medical or other information with respect to this vaccine to Medicare, Medicaid or other third party payer as needed to request payment of authorized benefits to be made on my behalf to Marquette County Health Department. I acknowledge that if my insurance does not cover the cost of administering the vaccine then I will be responsible for any balance on my account for which I will receive a statement. "**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

THIS SIDE OF FORM TO BE COMPLETED BY MARQUETTE COUNTY HEALTH DEPT STAFF ONLY

NURSE STAFF: \_\_\_\_\_

Date Vaccine Administered: \_\_\_\_\_

Vaccine	Manuf.	Lot #	Route	Site	Nurse Signature
Flu Q (IIV4) 0.5mL	Sanofi		IM	RD LD RT LT	
Flu IIV3 High Dose	Sanofi		IM	RD LD RT LT	

Nurse Notes:

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