Tennessee Department of Health
Influenza Vaccination Adult Consent and Immunization Documentation Form

PLEASE PRINT

School or Location _____

Last Name_____ First Name_____ MI_____

Sex ☐ M ☐ F DOB ____/____/_____ Current Age _____

Race ☐ White ☐ Black ☐ Other Ethnicity: Hispanic ☐ Y ☐ N

Address_____ City _____State_____ Zip_____

Please check YES or NO for ALL questions

The following questions will help determine if there is any reason you should not receive an influenza immunization. Answering "yes" to any question does not prevent you from being vaccinated. It means additional questions will be asked. If a question is not clear, please ask your healthcare provider to explain.

1. Have you ever had a severe reaction to a flu shot? If yes, please describe: _____ ☐ Yes ☐ No
2. Are you allergic to eggs, gentamicin sulfate, gelatin, or arginine? ☐ Yes ☐ No
3. Are you sick today with a fever? ☐ Yes ☐ No
4. Do you have a history of Guillain-Barre Syndrome? ☐ Yes ☐ No

TENNCARE PATIENTS ONLY (Tennessee Department of Health will bill TennCare)

PATIENT'S NAME (as it appears on TennCare Card) _____

SSN_____ **TennCare ID#** _____ **Do you have**: ☐ **United Health Care** ☐ **Blue Care/TennCare Select** ☐ **AmeriGroup**

Do you have private insurance AND TennCare? ☐ Yes ☐ No If yes, please provide private policy information on the back of this form.

MEDICARE PATIENTS ONLY (Tennessee Department of Health will bill Medicare)

PATIENT'S NAME (as it appears on Medicare Card) _____

PATIENT'S MEDICARE NUMBER: _____ **EFFECTIVE DATE:**_____

Do you have private insurance AND Medicare? ☐ Yes ☐ No If yes, please provide private policy information on the back of this form.

PRIVATE INSURANCE PATIENTS (Tennessee Department of Health will bill your insurance company)

PATIENT'S NAME (as it appears on insurance card) _____

NAME OF INSURED: _____ **RELATIONSHIP TO PATIENT:**_____

INS. COMPANY NAME: _____ **POLICY NUMBER**: _____

MEMBER ID: _____ **GROUP NUMBER**: _____

CLAIM ADDRESS: _____

_____

I have been given a copy of the Vaccine Information Statement and the Department of Health's Notice of Privacy Practices.

PATIENT'S SIGNATURE: _____ DATE: _____

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Nursing Immunization Documentation

AREA FOR OFFICIAL USE ONLY

Manufacturer: ↑Sanofi ☐ ↑ Seqirus ☐ ↑ GSK ☐ Other ☐ _____

VIS Date: _____/_____/_____

Lot number:_____ **Site administered: ☐ Right Deltoid ☐ Left Deltoid**

Date Given: _____ **Signature_____**

Signature above indicates immunization given according to PHN Protocol

Provider Number: _____