SANDERS COUNTY HEALTH DEPARTMENT

INFLUENZA CONSENT FORM 2026

PATIENT INFORMATION

Name (first & last): _____ Date of birth: _____ Phone #: _____

Mailing address: _____ City: _____ State: _____ Zip: _____

If patient is under 18, parent/guardian first & last name: _____

INSURANCE INFORMATION

Do you have health insurance? ☐ Yes ☐ No
(Not insured, skip to Influenza Vaccine Screening)

SSN #: _____

Health Insurance: _____ Member ID or Medicare #: _____ Group #: _____

Health Insurance: _____ Member ID or Medicare #: _____ Group #: _____

VA Member #: _____

REGISTRATION USE ONLY: Card scanned: ☐ Medicare Part B active: ☐ Yes ☐ No

INFLUENZA VACCINE SCREENING — PLEASE CHECK YES OR NO

1. Do you currently have an infection, fever, or acute illness? ☐ **No** ☐ **Yes**

2. Have you ever had an allergic reaction to any component (part) of an influenza vaccine? ☐ **No** ☐ **Yes**
If yes, describe: _____

3. Have you ever developed Guillain-Barré syndrome within 6 weeks of receiving an influenza vaccine? ☐ **No** ☐ **Yes**
If yes, describe: _____

4. Have you ever had an allergic reaction to eggs or egg products? ☐ **No** ☐ **Yes**

5. Do you have any allergies to medicine, food, or latex? ☐ **No** ☐ **Yes**
If yes, describe: _____

6. Is the person receiving the influenza vaccine currently pregnant? ☐ **No** ☐ **Yes**

7. Are you currently taking any medications or receiving long-term aspirin therapy? ☐ **No** ☐ **Yes**

8. Have you taken an antiviral medication for influenza within the last 48 hours? ☐ **No** ☐ **Yes**

INFLUENZA CONSENT

I have read, or had explained to me, the Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of vaccination as described. I request that the influenza vaccination be given to me, or to the person named above for whom I am authorized to make this request.

Signature of recipient or parent/guardian: _____ **Date:** _____

IMMTRAX DATABASE CONSENT

I authorize the public health department to collect and enter my, or the person listed above's, immunization records into the Department of Public Health and Human Services Immunization Information System. This confidential computer system contains immunization records. I understand that registry information may be released to a public health agency and my health care providers to assist in my medical care and treatment. I understand that I may revoke this authorization and have my record removed at any time by contacting my local health department.

Signature of recipient or parent/guardian: _____ **Date:** _____

NURSE USE ONLY

Admin date: _____ **Dosage:** ☐ 0.5 mL ☐ High Dose **Site:** _____ **Lot #:** _____

Nurse signature: _____

VIS date: 1/31/2025

Billed: ☐ **Amount:** $_____