



2026-27 ADULT FLU CONSENT



PATIENT INFORMATION

1115 Pecan Drive Weatherford, TX 76086
(817) 458-3254 pchdtx.gov

FULL NAME: _____

Date of Birth: ____ / ____ / ____

Age: ____

Gender: ☐ Male ☐ Female

ADDRESS: _____

CITY: _____

ZIP CODE: _____

CELL PHONE NUMBER: _____

REQUIRED INSURANCE INFORMATION (PLEASE CHECK THE BOX THAT APPLIES):

By completing the following insurance, I authorize payment of medical benefits for any services provided. This information will be used for the purpose of evaluating and administering claims of benefits.

☐

AETNA

☐

BLUE CROSS

☐

CIGNA

☐

UNITED

☐

OTHER

Subscriber (Policy Holder) Name: _____

Subscriber (Policy Holder) DOB: ____ / ____ / ____

MEMBER ID (POLICY) NUMBER: _____

GROUP NUMBER: _____

☐

Medicare ****(card must be presented at time of service)****

☐

I do not have health insurance coverage at this time.

THIS SECTION FOR TRICARE ONLY

TRICARE Military Insurance

THIS SECTION FOR TRICARE ONLY

Subscriber (Policy Holder) Name: _____

Subscriber (Policy Holder) DOB: ____ / ____ / ____

Subscriber SS# NUMBER: _____

Subscriber DOD NUMBER: _____

VACCINATION AND HEALTH QUESTIONS:

☐

1. Is the person to be vaccinated feeling sick today?

YES

NO

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2. Has the patient ever had a severe or life threatening allergic reaction to the flu vaccine?

YES

NO

☐

3. Does the patient have an allergy to any components of the flu vaccine?

YES

NO

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4. Has the patient ever been diagnosed with Guillain-Barre Syndrome?

YES

NO

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5. Has the patient ever felt dizzy or faint before, during or after a shot?

YES

NO

Authorization for the Administration of the Influenza Vaccine

I am providing this consent form to Parker County Hospital District in order that I may be given the influenza vaccination. I have read and understand the information I have received concerning the possible benefits and side effects of the influenza vaccination. I hereby acknowledge that based on the information presented to me, I am eligible to receive the influenza vaccination on this date. I am feeling well today and I have not recently had a fever. I understand that no assurance can be given that the influenza vaccination will give me immunity from contracting ANY strain of influenza. I hereby acknowledge that I have received access to a copy of the Vaccine Information Sheet, via the provided QR code, on the 2026-2027 Influenza Vaccine. I release Parker County Hospital District, its employees, representatives and agents from any liability for giving me the influenza vaccination. I accept responsibility for seeking medical attention for any problems associated with my receiving the vaccine. I have had the opportunity to have all my questions answered. I understand that this consent is valid for 6 months and I will make PCHD aware of any changes prior to being vaccinated.

Signature of Patient _____

Date _____

PCHD Staff Signature _____

Date _____

Clinic Location: _____

Location: _____

Date: ____ / ____ / ____

LA RA

Vaccine Lot #: _____

Expiration Date: _____

Administered by: _____

For detailed information about the flu vaccine, scan this QR code with your phone

