

PEDIATRIC FLU & FLUMIST VACCINE CONSENT 2011-2012



****PLEASE PRINT****

We would be happy to assist you in completing this form.
Please have all health insurance cards ready to present for review.

Date: _____
 Clinic Site: _____
 Patient's Home
 NBHV BCMH

Name:	Birth Date:	Age:	VFC-Eligible <input type="checkbox"/>
Address:			
City:	State:	Zip:	
County:	Political Subdivision or Township:		
Phone Number:	<input type="checkbox"/> Female <input type="checkbox"/> Male		

Is your child enrolled in Medicaid or a Medicaid HMO (CareSource, WellCare, Buckeye)? Yes No
 Is your child without health insurance coverage? Yes No
 Is your child a Native American or Alaskan Native? Yes No

Does your child's health insurance cover vaccinations? Yes No
 Has the annual maximum amount of vaccine coverage for this child been met this year? Yes No
 Has the annual deductible for this child been met this year? Yes No

For Medicaid Consumers: Do you have any other health insurance coverage? Yes No

We accept Medicaid, WellCare, CareSource, and Buckeye Community Health Plan as payment in full. If coverage under these plans is not in effect today, we will bill you directly for the full amount of today's services. We are unable to bill private insurance companies.

Please indicate your primary and secondary insurance company and I.D. number:		Parent or caregiver photo ID presented & verified: <input type="checkbox"/> Staff Initials _____
Name of Primary Insurance Plan: _____	ID Number: _____	
Name of Secondary Insurance Plan: _____	ID Number: _____	
Social Security # _____ (Required <u>only</u> if billing insurance company for today's services)		

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government health benefits to the Medina County Health Department who accepts assignment. I have read or been given a copy of the Medina County Health Department's Notice of Privacy Practices and have been given the opportunity to have any questions answered.

Printed Name of Parent/Guardian/Patient _____	Signature of Parent/Guardian/Patient to receive vaccine or person authorized to make request. _____	Date _____	For Staff Use Only: Triage RN _____ Admin. Support _____
Amount Paid _____	Receipt # _____	Receipt Date: _____	
<input type="checkbox"/> Cash <input type="checkbox"/> Visa <input type="checkbox"/> MC	<input type="checkbox"/> Ck# _____	Staff In. _____	
Fee waived due to inability to pay <input type="checkbox"/> _____ (Supervisor Signature)			

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ODH X

Your child may be eligible to receive FluMist (nasal flu vaccine). Certain people must not receive FluMist. You must answer each question below, and have the answers reviewed by the public health nurse to ensure that your child is eligible to receive FluMist.

Precautions and Contraindications: Please mark YES or NO for each question.		YES	NO
1.	Is your child well today?		
2.	Is your child allergic to eggs, Formaldehyde, Neomycin, Polymyxin B, Sucrose, Gentamicin, Gelatin, Arginine, Monosodium Glutamate (MSG), or Thimerosal?		
3.	Has your child ever had any bad reaction to a flu vaccine?		
4.	Has a doctor ever told you that your child has an immune system disorder?		
5.	Does your child have AIDS, HIV, cancer, or received an organ transplant?		
6.	Does your child have a history of asthma, reactive airway disease, or recurrent wheezing, or does your child have any disease of the lungs, including chronic bronchitis, recurrent wheezing, emphysema, or cystic fibrosis?		
7.	Did your child ever have Guillain-Barre syndrome?		
8.	Is your adolescent child pregnant or breast-feeding?		
9.	Does your child have kidney, liver, or heart disease (angina, congestive heart failure,) or has your child ever had a heart attack or stroke?		
10.	Does your child have a blood disease or any type of anemia?		
11.	Does your child currently have a respiratory illness or a fever?		
12.	Has your child received any vaccines within the last month, or do you plan to have your child receive any vaccines within the next month?		
13.	Is your child taking any prescription medicines or antivirals?		
14.	Is your child currently receiving aspirin or aspirin-containing therapy?		
15.	Does your child have diabetes or other metabolic disease?		
16.	Is your child in close contact with severely immunocompromised individuals who require a protective environment (such as bone marrow transplant recipients)?		

Consent for Vaccine Administration:

I have truthfully answered all of the questions on this form. I have also received and have read a copy of the 7/26/11 Vaccine Information Statement (VIS) for the appropriate influenza vaccine (TIV, LAIV). I have had the opportunity to ask questions and fully understand the benefits and risks of vaccination against seasonal influenza. My signature below indicates my permission for seasonal influenza vaccine to be given to my child.

Printed Name of Parent/Guardian/Patient

Signature of Parent/Guardian/Patient to receive vaccine or person authorized to make request.

Date

Signature of RN completing assessment

Date

- First Dose
 Second Dose

CLINIC USE ONLY

Vaccine Information Statements given as noted.

Immunization Given	Lot # Mfr: Sanofi	Injection Site	Vaccine Adm. Signature & Title	ODH	PVT Thimerosal-Free
[] Influenza		Left Deltoid IM			
[] Influenza		Left Anterolateral Thigh			
[] FluMist		Intranasal			

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