TWO RIVERS PUBLIC HEALTH DEPARMENT INFLUENZA CONSENT FORM

PATIENT INFORMATION

SCHOOL	CITY

LAST NAME	FIRST NAME	MI	MAIDEN NAME (IF APPLICABLE)

DATE OF BIRTH	AGE	SEX at BIRTH	MOTHER'S MAIDEN NAME (FIRST AND LAST)	PHONE
_ _/ _ _/ _ _ _ _		M F		( )

STREET ADDRESS	P.O.BOX (IF APPLICABLE)	CITY	STATE	ZIP

RACE □ WHITE □ ASIAN □ AMERICAN INDIAN/ALASKAN NATIVE □ AFRICAN AMERICAN ETHNICITY □ NOT HISPANIC OR LATINO □ HISPANIC OR LATINO

INSURANCE INFORMATION

RELATIONSHIP OF PAITENT TO INSURANCE SUBSCRIBER □ SELF □ SPOUSE □ CHILD □ OTHER

SUBSCRIBER NAME (IF DIFFERENT THAN ABOVE)	SUBSCRIBER BIRTH DATE	SOCIAL SECURITY #
	_ _/ _ _/ _ _ _ _	

STREET ADDRESS (IF DIFFERENT THAN ABOVE)	CITY	STATE	ZIP
			-

PHOTO OF CARD (FRONT & BACK) □ PHOTOCOPY ATTACHED

INSURANCE PROVIDER

☐ BLUE CROSS BLUE SHIELD
☐ UNITED HEALTH CARE
☐ MEDICAID: **CIRCLE ONE**
UHC NTC Molina
☐ MEDICARE (SS# REQUIRED)
☐ NO INSURANCE
☐ OTHER:_____

SCREENING QUESTIONNAIRE- Questions must be completed before vaccine is administered

DO YOU HAVE ALLERGIES TO EGGS OR A VACCINE COMPONENT?	**YES**	**NO**	**UNKNOWN**
HAVE YOU EVER HAD DIFFICULTY BREATHING AFTER RECEIVING A VACCINATION?	**YES**	**NO**	**UNKNOWN**
HAVE YOU HAD A SEIZURE, BRAIN/NERVOUS SYSTEM DISORDER OR GUILLAIN-BARRE?	**YES**	**NO**	**UNKNOWN**

I GIVE CONSENT to the **Two Rivers Public Health Department** and its staff to vaccinate the person listed on this form. I have read or had explained to me the Emergency Use Authorization or been provided a Vaccine Information Statement and understand the risks and benefits. I hereby grant permission to Two Rivers Public Health Department to release any pertinent information to the above insurance company upon request and any physicians to whom I might be referred. I agree and acknowledge that TRPHD or any of its volunteer's or partnering agencies, are not liable for the actions or omissions of, or the instructions given by the staff, volunteers, or partnering agencies who perform the vaccination.

_____ / /

Parent/Guardian Signature — Today's Date: *(month/day/year)*

VACCINE MANUFACTUER	LOT/EXP	DOSE	SITE	NURSE/DATE
FLULAVAL-90686 GSK		◯ 1-90471 ◯ 2-90471	LA RA	
			LA RA	
			LA RA	
			LA RA	
			LA RA	
			LA RA	

NESIIS: _____/_____ BILLED: _____/_____

TEMPERATURE: _____

Paid Cash/Donation _____