



FREMONT COUNTY DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT

201 N. 6th Street
Cañon City, CO 81212
P: 719-276-7450 F: 719-276-7451

Influenza Vaccine Consent Form

Name: _____ Date of Birth: _____ M: _____ F: _____
Phone #: _____ Type of Phone (Circle one): Home Cell Work
Address: _____ City: _____ State: _____ Zip: _____

You should not receive the Influenza vaccine if any of the following apply:

- You have ever had a serious allergic reaction to eggs or to a previous dose of influenza vaccine.
- You have a history of Guillain-BarreSyndrome (GBS).
- You are ill.

QUESTIONS (REQUIRED)

CIRCLE YOUR RESPONSE

Do you Feel ill today or have a fever?	Yes / No
Are you allergic to egg or egg product?	Yes / No
Have you ever had a severe reaction to a flu vaccine?	Yes / No
Have you ever had Guillain-Bare Syndrome?	Yes / No
Are you allergic to Latex?	Yes / No
If you are female, are you pregnant?	Yes / No / NA
If for a child, has a flu vaccine been received in the past?	Yes / No / NA

INSURANCE/PAYMENT INFORMATION-

No Insurance (NI) [] Alaska Native (AN) [] American Indian (AI) []

Medicare #: _____ Medicaid #: _____

Private Insurance Name: _____

Policy #: _____ Group/Plan: _____

Subscriber's Name: _____ Subscriber's DOB: _____

By signing below, I hereby authorize Fremont County Department of Public Health & Environment to bill my insurance for reimbursement and request that payment of authorized benefits be made to Fremont County Department of Public Health & Environment.

I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Sheet. I have had a chance to ask questions and they were answered to my satisfaction. **I attest that the above information is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health.** I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me. I understand that it will not be fully effective for approximately two weeks. However, as with all vaccines there is no guarantee that I will become immune or that I will not experience side effects. I understand that one should not receive this vaccine if they have a **severe** allergy to eggs, have had a severe reaction to a previous influenza vaccine, or if they have had Guillain-BarreSyndrome.

Patient/Parent Signature: _____ **Date:** _____

FCDPHE OFFICE USE ONLY

Manufacturer: _____ Lot #: _____ VIS Date: _____

Dose: 0.25cc _____ 0.5cc _____ Injection Site: _____

Administered By: _____ Date: _____