ARKANSAS DEPARTMENT OF HEALTH
INFLUENZA SEASON -- IMMUNIZATION CONSENT FORM

For ADH use only ADH Clinic Code: _____ School LEA #: _____ Date Of Service: _____
School Name: _____ School Grade: _____

Person Receiving Vaccine:

(Legal) First Name: _____ **MI:** ____ **Last Name:** _____
Date of Birth: ☐☐ ☐☐ ☐☐☐☐

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.

*If YES and further guidance is needed, notify the Regional CDNS	*YES	NO	
Do you have a fever today? (If you have a fever on the day of the clinic it may prevent you from receiving the influenza vaccine.)			If any answer is YES, you may not be able to receive the flu vaccine.
Have you ever had a serious reaction to a previous dose of flu vaccine, such as difficulty breathing, swelling of eyes or lips, wheezing, or immediate nausea or vomiting? Do you have a severe allergy to any foods or medications? (i.e., gelatin, gentamicin or neomycin)			
Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?			
Are you younger than 2 years? ☐ Yes ☐ No Are you older than 49 years? ☐ Yes ☐ No			If any answer is YES, you can receive only the injectable flu vaccine (shot), not the intranasal flu vaccine (flu mist).
Are you pregnant?			
Do you have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood? For a child 2 through 4 years: Have you been told by a health care provider that your child had wheezing or asthma in the past 12 months?			
Are you on long-term aspirin or aspirin-containing therapy? Do you take aspirin every day? Have you received influenza antiviral medications within the last 48 hours? (Tamiflu, Relenza, Rapivab, Xofluza)			
Have you received any of these vaccines in the last 28 days? Measles, mumps, rubella (MMR) ☐ Yes ☐ No Varicella (chickenpox) ☐ Yes ☐ No Intranasal influenza vaccine (Flu Mist) ☐ Yes ☐ No			
Do you have a severely weakened immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer, rheumatoid arthritis, Crohn's disease, psoriasis, or radiation treatments)?			
Do you have close contact with a person who needs care in a protected hospital environment (for example, someone who has recently had a bone marrow transplant)?			
For parents NOT attending flu clinic with their child: If you answered No to all of the above questions, your child may receive either the flu shot (injectable) or flu mist (nasal spray). Please mark your preference of vaccine type below. **If your preferred vaccine type is not available or marked, the nurse will give what is available unless you indicate otherwise.** ☐ **Flu Shot** ☐ **Flu Mist** ☐ **No Preference** ☐ **Do not give if my preference is not available** **Child's Homeroom Teacher:** _____ **(For school clinic use)**			
• NOTE: Children aged 6 months through 8 years may require a second dose. Contact your health care provider or your ADH Local Health Unit in four weeks for more information.			

2. RELEASE AND ASSIGNMENT. Please read the section on the reverse side of this form. The Arkansas Department of Health's Privacy Notice is on the website www.healthy.arkansas.gov, posted and available at the clinic site, or accompanies this form.
Then sign in the box at right.

Please sign here

My signature below indicates I have read, understand and agree to section 2. Release and Assignment of the Influenza Season -- Immunization Consent Form. and Vaccine Information Statement (VIS).

Signature of Patient/Parent/Guardian:

_____ date _____

RELEASE AND ASSIGNMENT:

- I have read or had explained to me the Vaccine Information Statements for the Inactivated Influenza Vaccine and the Live Attenuated Intranasal Vaccine (Flu Mist) and understand the risks and benefits. To read the Vaccine Information Statement (VIS) for each vaccine visit the website to view current VIS: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html
- I give consent to the State/Local Health Department and its staff for the individual named below to be vaccinated with the flu vaccine.
- I hereby acknowledge that I have reviewed a copy of the Arkansas Department of Health's Privacy Notice.
- I understand that information about this flu vaccination will be included in the Arkansas Department of Health's Immunization Registry.

To My Insurance Carrier(s):

- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to the Arkansas Department of Health.
- I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.
- I agree that the photocopy of this form may be used instead of the original.

3. PATIENT INFORMATION:

(Legal) First Name: _____ MI: ____ Last Name: _____

Date of Birth: ☐☐/☐☐/☐☐☐☐ Gender: ☐ Male ☐ Female Phone #: _____

Street Address: _____ P.O. Box _____ Apt. No. _____

City: _____ State: _____ Zip Code: ☐☐☐☐☐

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African-American ☐ American Indian/Alaska Native
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other

4. INSURANCE STATUS (Check appropriate box):

Patient's Relationship to Insurance Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

☐ Medicaid/ARKids Number: ☐☐☐☐☐☐☐☐☐☐☐☐

☐ Medicare Number: ☐☐☐☐☐☐☐☐☐☐☐

☐ Insurance Company Name: _____

Member ID/Policy #: ☐☐☐☐☐☐☐☐☐☐☐☐☐

REQUIRED POLICY HOLDER Information:

(Legal) First Name: _____ MI: ____ Last Name: _____

Policy Holder Date of Birth: ☐☐/☐☐/☐☐☐☐ Email Address: _____

Policy Holder's Employer Name: _____

Flu Vaccine Administration (Completed by ADH staff only)

SHOT CODE:

☐ 70: Quadrivalent (P-F) ≥ 6 months ☐ 39: Quadrivalent Intranasal vaccine (P-F) 2 - 49 years

	Route	Site Code	Dosage mL.	MFG Code	Lot Number
Flu Vaccine	☐ IM ☐ Intranasal				

Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Leg = RL, Left Leg = LL, Right Arm = RA, Left Arm = LA

MFG Codes: SKB = GlaxoSmithKline, PMC = Sanofi, MED = MedImmune, SEQ = Seqirus

Signature and Title of Vaccine Administrator: _____

Date Vaccine Administered: ____/____/____