

TOOELE COUNTY HEALTH DEPARTMENT
SCHOOL FLU CONSENT FORM

Student Name:		Grade:	Teacher:		School:
Address:		City:		State:	Zip:
Phone:		Date of Birth:		Age:	Race:
Sex:		E-Mail:			
Cell:	May we text you? Yes No		E-Mail:		
Insurance Name:		Member ID #:		Group #:	
Policy Holder Name:			Policy Holder Birthdate:		
Secondary Insurance Name:		Member ID #:		Group #:	
Policy Holder Name:			Policy Holder Birthdate:		

The person receiving the vaccine:

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | has a serious allergy to any foods or medications |
| <input type="checkbox"/> | <input type="checkbox"/> | has had a serious reaction to a vaccine in the past. |
| <input type="checkbox"/> | <input type="checkbox"/> | is on aspirin therapy, chemo/radiation therapy. |
| <input type="checkbox"/> | <input type="checkbox"/> | has been paralyzed by Guillain-Barre Syndrome. |
| <input type="checkbox"/> | <input type="checkbox"/> | has had immunizations in the last month. If yes, what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | has been sick in the last week, on an antibiotic or antiviral medication. |
| <input type="checkbox"/> | <input type="checkbox"/> | is pregnant, or has a chronic illness such as heart disease, lung disease, diabetes, asthma, kidney or liver disease, anemia or other blood disorder. |

I have been given a copy and have read, or had explained to me, the information in the Vaccine Information Statement. I understand the benefits and risks of the vaccine and request that the vaccine be given to me or the person for whom I am authorized to make this request. I agree that this information may be shared with schools, daycare centers, healthcare providers and others when medically necessary. I have been given a copy of the Notice of Privacy Practices and have had a chance to ask questions. I understand it is my responsibility to know what my insurance plan covers and agree to pay the portion not covered by my insurance. I understand that if the Health Department does not have a contract with my insurance company, or payment is denied, I am responsible for all charges incurred.

Client/Guardian Signature: _____ Date: _____

If paying by credit card please fill out below:
 [] Visa [] MasterCard [] Discover [] American Express
 Card # _____ Exp. Date _____
 Amount \$ _____ Signature _____

To pay on-line, go to
www.tooelehealth.org
Please Check box if Paid On-Line

***** Space Below for Public Health Nursing Information Only *****

ICD 10:90687-SL VFC/Private 90687preserve <3
 IM lateral thigh L R 0.25 ml
 Lot # _____

ICD 10:90688-SL VFC/Private 90688 >3
IM Deltoid L R 0.5 ml
Lateral thigh L R 0.5 ml
 Lot # _____

Nurse: _____ Provider # _____ E _____ Amount Paid _____