



Influenza Immunization Questionnaire / Consent Form

PATIENT Name _____ Phone (____) _____

Mailing Address _____ City/State/Zip Code _____

Birth Date ____/____/____ Age Today _____ Gender F M History of Chicken Pox Yes No

Race (Check one box only)			Ethnicity (Check one box only)		Patient's Social Security # ____-____-____ <small>Required to access your immunization records online</small>
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic/Latino		
<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Not Hispanic/Latino			

Insurance Status (Check one box only) * Please include a copy of the front and back of insurance card

Insured: Insurance Company: _____ Insurance/ID #: _____
Group #: _____ Policy Holder Name: _____ Birth Date: ____/____/____

Medicaid / NV Check Up #: _____ **Medicare #:** _____ **Policy Holder Relationship to Patient:** _____

Uninsured / No insurance **Insured, but vaccines are not a covered benefit**
* Please include \$20 for administration fee or whatever you can afford

Please answer the following questions about THE PERSON to be vaccinated

1. Sick today?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Allergic to eggs, latex, food, medication, vaccine ingredients? If yes, list: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Had a serious reaction to or fainted with previous immunization?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Had Guillain-Barre syndrome in the past?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Had seizure or other nervous system problem?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Have cancer, AIDS or other immune system problems?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Taken cortisone, prednisone or any steroids, anti-cancer drugs, or radiation in the last 3 months?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Received antiviral drugs in the last 3 months?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. Received any other immunizations, including influenza, in the last month? If yes, list: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
10. Received a blood or blood product transfusion, or been given immune (gamma) globulin in the last year?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
11. Have long-term medical problems: diabetes, heart, kidney or lung disease, asthma, wheezing or blood disorders?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
12. Pregnant or plan to become pregnant in the next month?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
13. Been vaccinated against influenza (flu) in the past?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

I have received and understand the vaccine information sheet(s) for the immunization(s) to be administered. I authorize CCHHS to enter this information into the Nevada Immunization Registry, unless otherwise specified. I understand the CCHHS Notice of Privacy is available at gethealthycarsoncity.org/immunizations. I hereby authorize & direct payment of medical benefits to CCHHS for any services provided to me or my dependents.

If my carrier deems these services non-payable, I agree that I am financially responsible for any outstanding balances.

Client/Parent/Guardian Signature _____ Date ____/____/____
Parent/Guardian signature required if under 18 years old

Client/Parent/Guardian Print Name _____ Email: _____

CLINIC USE ONLY – DO NOT WRITE BELOW THIS LINE						Circle Location Below		
						RD	LD	IM

Administered by: _____ Date: ____/____/____ Clinic Location: _____
(Write Legibly) First Initial Last Name Credential

Amount \$: _____ <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> CC	\$ Reconciliation:	WebIZ:	eCW/Scan:	eCW Charting:
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