



Public Health
Present. Promote. Protect.

Full Legal Name: _____

Date of Birth (Month/Day/Year): _____ Age: _____

Gender: Male Female Transgender Declined to Specify | Race: White American Indian/Alaska Native Black/African American Asian/Pacific Islander Unknown Declined to Specify |

Ethnicity: Not Hispanic or Latino Hispanic or Latino Unknown Declined to Specify

School Name or Clinic Site: _____

Parent/Guardian (if applicable): _____

Patient Address: _____ City: _____

State: _____ Zip Code: _____ County: _____ Phone Number: _____

HEALTHCARE COVERAGE

Medicaid/Medicare Private Insurance does not pay for vaccines Uninsured

If you have health insurance, attach copy of card to this consent form.

Please consider a \$20 donation to cover cost of supplies if uninsured or insurance does not pay for vaccines. No one will be turned away due to inability to pay.

If answered "yes" to any question below, additional information may be needed. If a question is not clear, please contact the health department for clarification in advance at (573) 897-3103.

Are you/your child sick today? (We will ask the child the day of the clinic) Yes No Unknown

Do you/your child have allergies to medication, eggs, latex, or any vaccine? Yes No Unknown

List allergies (if applicable): _____

Have you/your child ever had a serious reaction after receiving a vaccination? Yes No Unknown

Have you/your child had a seizure, brain or neurological problem, or ever had Guillian-Barre Syndrome? Yes No Unknown

For children only: Has your child ever received an influenza vaccine? Yes No Unknown N/A

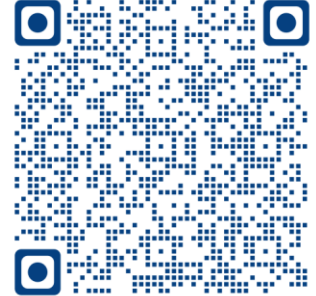
OSAGE COUNTY HEALTH DEPARTMENT

1218 E Main St
Linn, MO 65051
(573) 897-3103

INFLUENZA VACCINE
CONSENT FORM



I have read, or had explained to me, the Vaccine Information Statement (VIS) about influenza vaccination. I understand the benefits and risks of the vaccination as described. I request that the influenza vaccination be given to me (or the person named above for whom I am authorized to make this request pursuant to Section 431.058 RSMo). I authorize the release of any medical or other information necessary to process a health insurance claim or for other public health purpose. I understand that any fees not paid by my health insurance are my responsibility. I have read and understand the HIPPA Notice of Privacy Practices located on our website at osagecountyhd.org.



Do you have a preference where your child receives their vaccine (arm or leg)? Yes (location) _____ No

Signature: _____ (Circle: Self/Parent/Guardian/Designee)

Date: _____

CLINICAL USE ONLY:

Name: _____ DOB: _____

VFC 317 Private

VIS Date:	
GSK	SP
Lot #:	_____
Exp:	_____
IM	RD LD RT LT

X _____ Nurse _____ Date Administered/VIS Given

X _____ Nurse _____ Date Administered/VIS Given