OSAGE COUNTY HEALTH DEPARTMENT
1218 E Main St
Linn, MO 65051
(573) 897-3103

INFLUENZA VACCINE
CONSENT FORM

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

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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