REDFIELD CLINIC

2021-22 ADULT INFLUENZA VACCINATION CONSENT FORM

Form must be filled in completely. Please Print.

Last name:_____ First Name:_____MI:_____

Gender: M_____ F_____ Age:_____ Date of birth:_____ Daytime Phone:_____

Mailing Address:_____Zip Code:_____

_____**Please check** if you are a CMH/Redfield Clinic Healthcare Worker/Family Member, Redfield City Employee/Family Member, or Spink County First Responder. Service will be billed to insurance; remaining balance is waived.

Please circle one: Self Pay Medicaid Insurance Medicare (**if Medicare no other insurance info is needed)**

Medicare or Medicare Replacement Plan Number_____Medicaid Number_____

Insurance Company_____ Insurance Company Address_____

Policy Holder's Name_____Policy Number_____Group Number_____

Please answer the following questions to determine your eligibility to receive this vaccine.

		YES	NO	Don't Know
1	Do you feel sick today?			
2	Do you have an allergy to a component of the vaccine?			
3	Have you ever had a serious reaction to influenza vaccine in the past?			
4	Have you had Guillain-Barre Syndrome?			

I have been given, read, or have been explained to the information in the Vaccine Information Statements for Influenza Vaccine. I understand the benefits and risks of Influenza Vaccine request that the vaccine be given to the person above for whom I am authorized to make this request. I also allow immunization information to be entered into the SD Immunization System (SDIIS) and/or be released to other medical care providers to prevent unnecessary vaccination or to ascertain immunization status**.**

_____

Signature of Patient/Representative Date

For Clinic Use Only:

Date	Vaccine	Manuf.	Lot #	Exp date	Dose/Route	VIS	Site	Source	Signature
					0.5ml	08/06/21	L R Deltoid Thigh	Private State	

Billing_____ SDIIS _____ Roster _____