INFLUENZA (IIV/RIV) VACCINE CONSENT FORM AND ADMINISTRATION RECORD 2020-2021

WyVIP/VFC Eligibility (Please Circle what applies:) Medicaid Uninsured Underinsured Insured Native/Alaskan American WY Resident Non-Resident

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)

Name: _____

Birth Date and Age: _____ Sex: Male Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Doctor: _____

Email: _____

Age Group	Dosage Schedule
9 Years and older	**0.5ML: One dose**
6 Months – 8 Years	**0.5 ML: One dose*†**

** For children younger than 9 years of age, refer to the 2018 ACIP Recommendations to determine the need for one or two doses. If two doses are needed, separate the doses by at least 4 weeks.*

†Dosage for age may vary by brand of vaccine. See package insert.

1. Have you received flu vaccine before? _____ ____No ____Yes
2. Did you have any problems with previous flu vaccine? _____ ____No ____Yes
3. Are you ill today? _____ ____No ____Yes
4. Do you have allergies to eggs, latex or to Thimerosal Mercury (a medication preservative)? ____No ____Yes
5. Do you have a history of Guillian-Barre Syndrome (a paralysis problem)? _____ ____No ____Yes
6. If you are younger than 9 years of age, have you received flu vaccine before? _____ ____No ____Yes
7. Have you received a pneumonia vaccine? ___ No ___ Yes If yes, what year? PPSV23 _____ PCV13_____

I have read, or have had explained to me, the Vaccine Information Statement (VIS) about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request (parent or guardian). If qualified, I authorize billing to my insurance company or my employer. I have received and read the Wyoming Department of Health Notice of Privacy Practices and have had a chance to ask questions about how my information will be used.

➡ Print Parent/Guardian name, if different from client: _____

✖ **Client/Parent/Guardian Signature**: _____Date: _____

PAYMENT INFORMATION:

Medicare#_____ Medicaid#_____

Other Pay Source: _____ **PAID BY: CASH_____ CHECK #_____**

Insurance Information	
Primary Carrier Insurance Company	Employer of Policy Holder
Insurance Carrier Mailing Address City State/Zip	Policy Holder DOB: Policy Holder's Sex:
Policy Holder's Name	Policy # Group #

FOR CLINIC USE ONLY

CLINIC SITE: **UINTA COUNTY PUBLIC HEALTH** VIS DATE: AUGUST 15, 2019

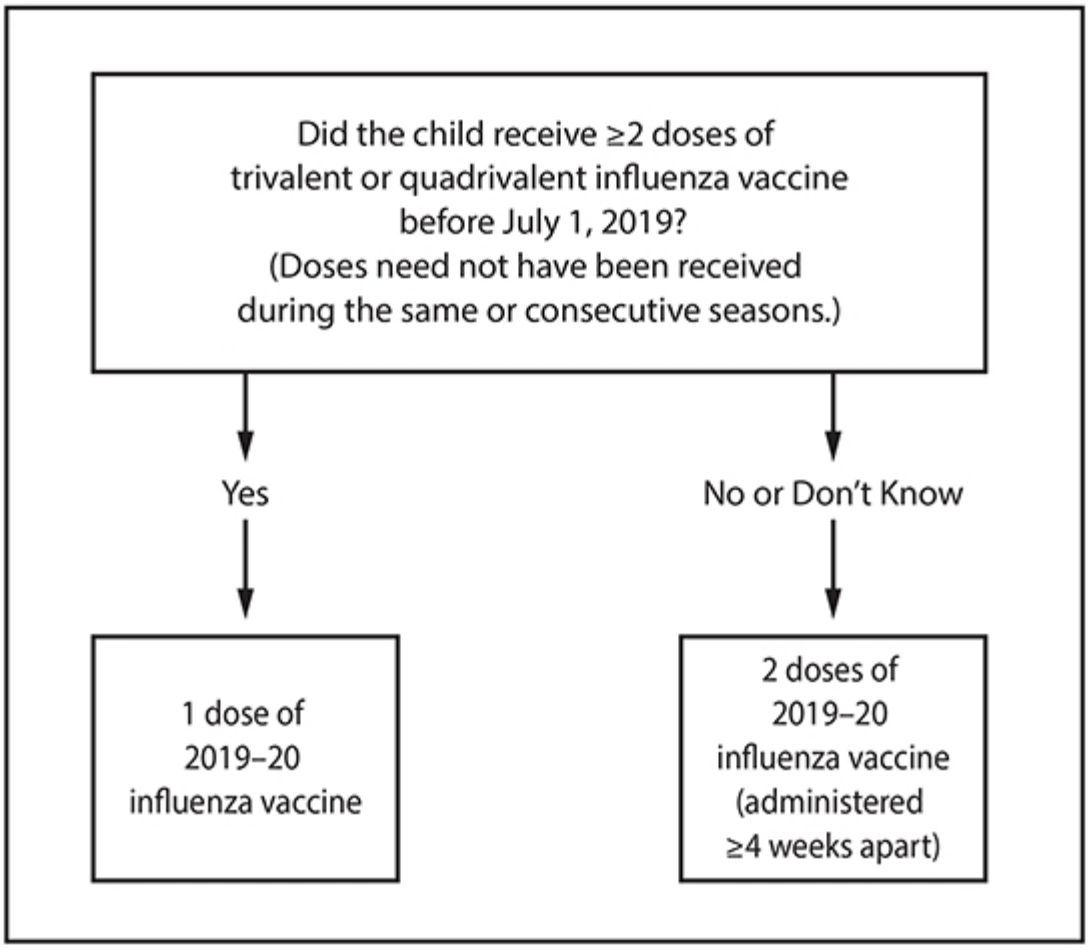
DATE VACCINE ADMINISTERED: _____ BOOSTER REQUIRED? NO YES -- DATE: _____

VACCINE MANUFACTURER & LOT NUMBER: _____ _____ IIV3 IIV4 HD-IIV4 RIV4 CCIIV4 AIIV4

SITE OF IM INJECTION: RDT OR LDT RLT OR LLT DOSE: 0.5ML 0.25ML

SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR: _____

NURSE'S COMMENTS: _____ _____ FORM REVIEWED BY:_____


Did the child receive ≥2 doses of trivalent or quadrivalent influenza vaccine before July 1, 2019? (Doses need not have been received during the same or consecutive seasons.)
Yes
No or Don't Know
1 dose of 2019–20 influenza vaccine
2 doses of 2019–20 influenza vaccine (administered ≥4 weeks apart)