

2020-21 Influenza Vaccine Consent Form
(complete both sides of form)

School Site: GFW

Sibley County Public Health and Human Services
111 8th Street, PO Box 237, Gaylord, MN 55334 (507) 237-4000, fax (507) 237-4031

Information about person to receive vaccine (Please print)

Student's Name (Last)	(First, Middle initial)	Date of Birth	Age	Gender M F	Hispanic Non-Hispanic
Address: Street, PO Box		City	State	County	Zip Code
Parent /Legal Guardian's Name (Last)	(First, Middle Initial)	Parent/Legal Guardian Daytime Phone Number:			

Immunization information may be shared through the Minnesota Immunization Information Connection (MIIC) with other healthcare providers, schools, health departments and others authorized under law to receive it. If you have any questions, please contact your health care provider. If you decide not to have this information shared with MIIC, please call 1-800-657-3970.

Assignment of Benefits and Responsibilities for Payment: This allows us to bill your health plan or company and receive payment directly. It also means that you agree to pay for services not covered by your health plan. I authorize this health provider to bill my health plan or other payers on my behalf, and to receive direct payment of authorized benefits. I agree that it is my responsibility to pay for any health care services not covered by my health plan or company, including but not limited to copayments, deductibles and co-insurance.

Payment Information

Attach a copy of insurance card(s)!

Primary Insurance Carrier: _____
 Policy/ID/Member Number: _____ Group Number: _____
 Secondary Insurance Carrier: _____
 Policy/ID/Member Number _____ Group Number _____
 Policy Holder Name: (if different from vaccinee) _____ Date of Birth: _____

"I have read or have had explained to me the Vaccine Information Statement: "Influenza Vaccine: What You Need to Know." I have had a chance to ask questions that were answered to my satisfaction, and I understand the benefits and risks of the influenza vaccine as described. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request."

Signature of person to receive vaccine or the person authorized to make the request (parent/legal guardian):

x _____ DATE _____

PLEASE ANSWER HEALTH QUESTIONS BELOW

Health History

Yes No

- 1. Is the person to be vaccinated sick today? (Fever of 100.5 or higher on the day of the clinic)
- 2. Has the person to be vaccinated ever had Guillain-Barré Syndrome within 6 weeks of an influenza vaccination?
- 3. Does the person to be vaccinated have a life-threatening allergy to eggs?
- 4. Does the person to be vaccinated have a life-threatening allergy to a component of the vaccine? May include antibiotics, gelatin or latex
- 5. Has the person to be vaccinated ever had a reaction to a dose of flu vaccine that needed immediate medical attention?

PLEASE COMPLETE REVERSE SIDE

FOR CLINIC USE ONLY

Vaccination Date	VIS 8/6/2021 Provided	Vaccine Manufacturer, Lot #, and Expiration Date	Dose	Site	Route	Vaccinator Signature
			0.5 ml	RD LD RVL LVL	IM	

Eligibility: Insured (Private) MCHP child Uninsured _____ Underinsured _____
 Payment (if uninsured): Unable _____ \$20.00 or _____ cash or check # _____ received by _____
 Vaccine: Flulaval (Private) _____ CPT: 90686 Fluzone (VFC) _____ CPT: 90686 SL
 Fluzone (Private) _____ CPT: 90686 Fluairix (UUAV) _____ CPT: 90686 SL

PLEASE CHECK ONE OF THESE STATEMENTS:

Please attach a copy of both sides of your insurance card and attach a copy to this form if:

- 1. I am an adult, 19 years of age or older. I have insurance that will cover vaccinations.
- 2. My child, 18 years of age or younger, has insurance that will cover vaccinations.
- 3. My child is on a Minnesota Health Care Program (Medical Assistance, Minnesota Care, or a prepaid Medical Assistance plan).
- 4. I am an adult on a Minnesota Health Care Program (as described above).

OR

Please enclose \$20.00 cash or check made out to Sibley County Public Health and Human Services if:

- 5. My child does not have health insurance.
- 6. My child is American Indian or Alaskan native. (May be insured or uninsured.)
- 7. My child has health insurance, but it does not cover the cost of the flu vaccine.
- 8. My child has health insurance, but it has a "cap," and we have reached the cap for this year.
- 9. I am an uninsured adult.
- 10. I am an underinsured adult (vaccine not covered).

If you have questions regarding eligibility, please call our office at 507-237-4000.