**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.

**Type of Insurance**

- ☐ Private
- ☐ Medicaid/ Medical Assistance
- ☐ Medicare
- ☐ No Insurance

"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):

×_____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
MCHP adult Uninsured ____
Underinsured

Payment (if uninsured):
Unable _____
$20.00 or _____
cash or check # _____ received by ____

Vaccine:
Flulaval (Private) ____ CPT: 90686
Fluzone (Private)____ CPT: 90686
Fluzone (VFC)____ CPT: 90686 SL
Fluarix (UUAV)____ CPT: 90686 SL

## PLEASE CHECK ONE OF THESE STATEMENTS*:*

☐ 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**

☐ 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 please call our office at 507-237-4000.**