INFLUENZA (IIV/RIV) VACCINE CONSENT FORM AND ADMINISTRATION RECORD 2019-2020

WyVIP/VFC Eligibility: Medicaid Uninsured Underinsured Insured Native/Alaskan American WY Resident Non-Resident

Age Group	Dosage Schedule
9 Years and older	**0.5ML: One dose**
3-8 Years	**0.5 ML: One dose***
6 Months - 35 Months	**0.25 ML or 0.5 ML: One dose*†**

** For children younger than 9 years of age, refer to the 2019 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.

Information about person to receive vaccine (please print)

Name: _____

Birth date and age: _____ Sex: Male Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Doctor: _____

Email: _____

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 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_____

PAYMENT INFORMATION:

Medicare#_____ Medicaid#_____

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

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

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: _____

FOR CLINIC USE ONLY

CLINIC SITE: _____ VIS DATE: AUGUST 15, 2019

DATE VACCINE ADMINISTERED: _____DATE BOOSTER REQUIRED: _____

VACCINE MANUFACTURER & LOT NUMBER: _____ IIV3 IIV4 RIV4

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

SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR: _____

NURSE'S COMMENTS: _____

(Revised 08/2019; 11/2014 IIV Flu Consent Form F-110 Policy C-110)