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

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 2020 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 MAN. & LOT NUMBER: ______________________ IIV3 IIV4 HD-IIV4 RIV4 ccIIV4 aIIV4

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

SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR: ______________________________

NURSE'S COMMENTS: ______________________________