Harrison-Clarksburg Health Department

330 W Main Street
Clarksburg, WV 26301

2023-2024 Seasonal Influenza Consent/Administration Form

Today's Date: ______________________________ **Patients Age:** ______________

Patient Name __________________________ __________________________ _______
(Last) (First) (Middle Initial)

Mailing Address ____

City ____ **State** ____________ **Zip** ___________

Date of Birth ___/___/______ **Gender** __________ **Race** ______ **Phone #** ________________________
Month/Day/Year Male/Female

Yes	No	PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS
☐	☐	Is the person to be vaccinated sick today?
☐	☐	Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?
☐	☐	Has the person to be vaccinated ever had a serious reaction after receiving a vaccination?
☐	☐	Has a physician ever diagnosed the person to be vaccinated with Guillain-Barré Syndrome (GBS)?

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

The HCHD Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice of Privacy Practices is subject to change. A copy of our Notice is available upon request. By signing this form, you acknowledge that the HCHD Notice of Privacy Practices was made available to you.

CONSENT

You must be at least 18 years of age to sign. If under the age of 18, a parent or guardian's signature is required. I authorize the HCHD healthcare providers to administer treatment as deemed necessary for care of the patient named above. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment. I have been given, read, or had explained to me the Vaccine Information Statement(s) Influenza (08/06/2021) and any additional vaccines I have chosen to receive today and understand the risks and benefits.

X______________________________________ ____________________ Relationship to Patient: ____________________________
Signature **Date**

For Harrison-Clarksburg Health Department use only

INSURANCE: **Copy of *ALL* Insurance cards must be attached.**

☐ I Have No Insurance

Medicaid, you must provide us a copy of (**both** the paper card and plastic card)

Medicare, you must provide us a copy of (**both** Medicare Card and the Supplemental HMO)

Policy Holder Name If different than patient name above: ____________________ ____________________ __________
(Last) (First) (M.I.)

Policy Holder Birth Date ____/____/_________ Relationship to Policy Holder ______________________________
Month Day Year

Private	*VFC/ STATE*
Flu HD (High Dose)	Fluarix (6mths +)
LOT NUMBER / EXPIRATION	
INJECTION SITE - R - L	

_____________________________ _____________________
Nurse Signature **Date**