

INFLUENZA (IIV) VACCINE CONSENT FORM AND ADMINISTRATION RECORD 2016-2017

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

<u>Age Group</u>	<u>Dosage Schedule</u>
9 Years and older	0.5ML: One dose
3-8 Years	0.5 ML: One dose*
6 Months - 35 Months	0.25 ML: One dose*
<small>* For children younger than 9 years of age, refer to the 2016 ACIP Recommendations to determine the need for one or two doses. If two doses are needed, separate the doses by at least 4 weeks.</small>	
<small>Dosage for age may vary by brand of vaccine. See package insert.</small>	

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)

Name: _____

Birth Date and Age: _____ Sex: Male Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Doctor: _____

Email: _____

PAYMENT INFORMATION:

Medicare# _____ Medicaid# _____

Other Pay Source: _____ PAID BY: CASH _____ CHECK # _____

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 Medicare, Medicaid, Great West, 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: _____

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|---|--|---------|
| 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 medication 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 _____ | |

FOR CLINIC USE ONLY

CLINIC SITE: _____

VIS DATE: AUGUST 7, 2015

DATE VACCINE ADMINISTERED: _____

DATE BOOSTER REQUIRED: _____

VACCINE MANUFACTURER & LOT NUMBER: _____ IIV3 IIV4

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

SIGNATURE AND TITLE OF VACCINE ADMINISTRATOR: _____

NURSE'S COMMENTS: _____