Pottawattamie County Public Health

600 S 4th St, Council Bluffs, IA 51503 - Phone 712.242.1155 - Fax 712.242.1162

PREVENT. PROMOTE. PROTECT.

IMMUNIZATION CONSENT FORM 2019

***COPY OF INSURANCE CARD(S) *REQUIRED* ***

SECTION 1 - PLEASE PRINT LEGIBLY (INFORMATION FOR PERSON BEING IMMUNIZED)

LEGAL Name (FIRST MI LAST) _____ **Date of Birth** ___/___/_____ **Age** _____ **Gender** M F

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP COCDE** _____

PHONE _____(_____)_____ **EMAIL ADDRESS** _____@_____

SECTION 2 - INSURANCE INFORMATION (ALL must be the Primary Coverage) Complete PARTS A & B

PART A: Circle primary insurance:

Medicare / Medicaid

BCBS

Coventry/Aetna

Other: _____

PART B: Complete Insurance Information

Policy Holder Name_____DOB___/___/_____ M F

Policy ID #_____Policy Holder Last 4 SSN _____

Insurance Company Address _____

Relationship to insurance holder: Self Child Spouse Partner

SECTION 3 - Please select YES or NO in response to the following questions:

1. Sick or have a fever?	**Yes**	**No**
2. Have an allergy to eggs, latex, aluminum, yeast, thimerosal or Neomycin?	**Yes**	**No**
3. Had a serious reaction to a previous dose of any vaccine?	**Yes**	**No**
4. Have any neurological, seizures, central nervous system disorders, Guillain-Barre?	**Yes**	**No**
5. Pregnant or planning to be in the next 4 weeks?	**Yes**	**No**

CONSENT: I acknowledge that the medical information provided above is correct. I have been offered a paper copy or have been able to access an electronic copy of the NOTICE OF PRIVACY PRACTICES AND VACCINE INFORMATION STATEMENT, understood the risks/benefits and request that the vaccine be given to me or the person named for whom I am authorized to make this request. I understand that I/the person named, should remain on site for at least 10 minutes to be monitored for the possibility of reaction. I authorize the Pottawattamie County DPH to use the signature for consent to bill the insurance company/credit card and to authorize payment to the Division of Public Health. I understand that I will be responsible for the cost if my insurance does not cover this/these immunization(s). If above client is under 19 years, I attest that I am the child's parent or legal guardian and may provide consent for this/these immunization(s).

Individual or Parent/Guardian Signature_____**Date:**_____

Influenza Vaccine/Route:

- ☐ Fluarix - IM
- ☐ Fluzone Pres. Free
- ☐ FluLaval - IM
- ☐ FluMist - IN

Dose:

- ☐ **0.25mL (6-35mnths)**
- ☐ **0.5mL**

Site: **LD RD IN** **Other:_____**

Lot #:

Vaccine Name/Dose and Route: ***Site:*** ***Lot:***

☐ Rabavert 1.0mL - IM	**LD RD**	# _____
☐ Adacel 0.5mL - IM (≥ 7 years)	**LD RD**	# _____
☐ Energix B 1.0mL (≥ 20 years)	**LD RD**	# _____
☐ Havrix 1.0mL - IM (≥ 19 years)	**LD RD**	# _____
☐ Tubersol 0.1mL - ID	**LA RA**	# _____

Nurse Signature: _____**Date:**_____