Influenza Consent Form

This voucher permits the individual named below to receive influenza vaccine

BRING THIS VOUCHER WITH YOU

STAFF USE ONLY
Cash/Credit/Check # _____
Contract Pay: _____
Insurance: _____
KanCare Title 19: ☐ Title 21: ☐

Vaccine: Seasonal Influenza

Demographic Information

Name: _____
Address: _____
City, State, Zip: _____
Telephone: _____
Date of Birth: _____
Age: _____ Sex: ☐ M or ☐ F

Thomas County Health Department
350 S. Range, Suite #2
Colby, KS 67701
Phone: 785.460.4596
Fax: 785.460.4595
Visit our website at: www.thomascohealth.com
Find us on Facebook: @thomascountyhealthdept

Health History Information (Please check answer)

1. Has this person had a serious reaction to vaccine in the past? ☐Yes ☐No
   1a. Person had cardiac arrest, collapsed or called 911 after getting vaccine? ☐Yes ☐No
2. Does this person have an allergy to eggs or egg products? ☐Yes ☐No
   2a. Has this person had a reaction to eggs involving symptoms other than hives, such as angioedema, respiratory distress, lightheadedness, or recurrent emesis; or who required epinephrine or another emergency medical intervention? ☐Yes ☐No
3. Has this person ever had Guillain-Barre Syndrome (GBS)? ☐Yes ☐No
   3a. Person had a history of GBS within six weeks after having flu vaccination? ☐Yes ☐No
4. Is this Person allergic to Thimerosal or mercury products? ☐Yes ☐No
   4a. Person experienced respiratory distress or collapsed using Thimerosal products? ☐Yes ☐No
5. Is this Person currently having any signs or symptoms of COVID-19? ☐Yes ☐No
   5b. Has this person been advised by a healthcare provider that you are a suspect case of COVID-19, regardless of signs or symptoms? ☐Yes ☐No

I, the undersigned, certify that all the above information is correct to the best of my knowledge. I hereby authorize the recipient of this document to share this information with public health entities at the local, state and federal level for purposes of ensuring medication efficacy and safety. I have been offered a Notice of Thomas County Health Department Privacy Practices.

Client Signature: _____ Date Signed: _____

Clinician Use Only:

Vaccine Provided: ☐IM Location: ☐R ☐L ☐Deltoid ☐VL
Clinic Site: _____
Vaccinator's Signature:_____ Date: _____

LOT NUMBERS

Vaccine InformationStatements
VIS Date: 08/06/2021

WEBIZ: _____ Scanned: _____ Billed: _____