COCONINO COUNTY ARIZONA
Health & Human Services

2625 N. King Street, Flagstaff AZ 86004
Phone: 928.679.7222 Fax: 928.679.7351

2019-2020
Seasonal Flu Consent Form

Last Name	**First Name and MI**		**Mother's Maiden Name**	
Address	**City**	**State** **Zip**	**Phone #**	
Circle all that apply: African American Native American Hispanic Asian White Pacific Islander/Native Hawaiian Other:		**Gender (circle)** Female Male Transgender	**Date of Birth** _____/_____/_____	**Age**
Guardian and/or Emergency Contact Information First and Last Name:		**Phone Number:**	**Relationship to Patient:**	**Age**

INSURANCE	❑ Insured ❑ Uninsured ❑ AHCCCS ❑ Underinsured (Insurance does not cover flu shots)

Name of Primary Insurance		Subscriber Name	
ID#	Group#	SS#	DOB
Name of Secondary Insurance		Subscriber Name	
ID#	Group#	SS#	DOB

MEDICAL HISTORY	**YES**	**NO**	**Don't Know**
Is the person to be vaccinated sick today?	❑	❑	❑
Has the person to be vaccinated ever had a serious reaction after receiving the influenza vaccine?	❑	❑	❑
Does the person to be vaccinated have an allergy to any foods, medications or latex?	❑	❑	❑
Has the person to be vaccinated ever had Guillain-Barré syndrome?	❑	❑	❑
If 8 years-old or younger: Has the person to be vaccinated received two doses of flu vaccine before this flu season (July 2019)?	❑	❑	❑

I have read or received the Seasonal Influenza Vaccine Information Statement (VIS) and had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risk of the influenza vaccine and request to receive the vaccine today. I agree to have Coconino County Public Health Services District release my information about this vaccination to the Arizona State Immunization Information System (ASIIS) and other health care providers upon request. When insurance is billed, I hereby authorize CCPHSD to furnish information to insurance carriers concerning my visit and I assign payments for medical services rendered to CCPHSD. I understand financially I am responsible for all charges that are not covered by insurance. I have received a copy of the HIPAA Confidentiality Notice.

Patient/Guardian Signature _____ Date _____

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STAFF USE ONLY

Patient Name _____ DOB ____/____/____

Clinic Location: ❑ King Street ❑ Other_____

Fee: $30.00 Waived AHCCCS VFA VFC Private Insurance Self pay Contract_____

Receipt # _____ **Payment type:** Cash Credit Check

VACCCINE	MGF	LOT #	SITE	ROUTE	DOSE
Pediatric Fluzone 6-35 mos	Sanofi		LT RT	IM	0.25 mL
Fluzone 6 mos+ MDV w/preservative	Sanofi		RD LD LT RT	IM	0.5 mL
Fluzone 36 mos+ SDV/SYRG no preservative	Sanofi		RD LD LT RT	IM	0.5 mL
FluBlok 50 yrs+	Sanofi		RD LD	IM	0.5 mL
High Dose Fluzone 65 yrs+	Sanofi		RD LD	IM	0.5 mL

Notes:_____

_____

_____

Nurse Signature _____ Date administered, and VIS given _____/_____/_____

(Influenza VIS 8/15/19)