FLU FORM **Time In: _____**
Time Out: _____

LAST NAME: _____ **FIRST NAME: _____** **MAIDEN: _____**

ADDRESS: _____ **CITY/STATE: _____** **ZIP: _____**

PHONE #: _____ **SSN: _____-_____-_____** **DOB: _____** **SEX: M / F**

Influenza (Flu) Vaccine (Inactivated)
Vaccine Information Statement

I received or was offered a copy of the Vaccine Information Statement (VIS) for Inactivated Influenza Vaccine. I know the risks of the disease this vaccine prevents. I know the benefits and risks of the vaccine. I have had a chance to ask questions about the disease the vaccine prevents, the vaccine, and how the vaccine is given. I know that the person receiving the vaccine will have the vaccine put in his/her body to prevent the disease this vaccine prevents. I am an adult who can legally consent for the person named above to get the vaccine. I freely and voluntarily give my signed permission for this vaccine.

Disclosure of Protected Health Information

Our commitment here at CCNCPHD is to serve our customers with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information. During the course of serving your interests it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared:

• During treatment, we may find it necessary to acquire a laboratory analysis.
• For payment purposes, we may use the services of a billing service.
• During healthcare operations, we may need a second opinion for consultation with a subcontractor / physician, or need to share information between departments within the Health Department for future programs made available for improving patient care / health issues.

We here at CCNCPHD are committed to obeying all Federal, State and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by law. If you have any questions or comments regarding your protected health information, feel free to contact our Compliance Officer. I have read and understand the above Notice of Privacy Practices.

Signature of person to receive vaccine or person authorized to make this request (parent or guardian):

X_____ **Date: _____/_____/_____**

Parent/Guardian's name: _____ **Relationship: Mother Father Guardian**
Print Name (Circle One)

PLEASE COMPLETE: ANSWERS WILL BE REVIEWED BY NURSE

		Yes	No	Don't Know
1.	Do you have an allergy to eggs or to a component of the vaccine?			
2.	Have you had a serious reaction to the influenza vaccine in the past?			
3.	Are you sick today?			
4.	Do you have a fever?			
5.	Have you ever had Guillain-Barre syndrome? (disorder of the nervous system)			

FOR CLINIC USE ONLY

Corpus Christi – Nueces County Public Health District - Immunizations Clinic

Vaccine Given:_____ **Site of Injection:_____**

Nurses' Signature: _____ **Date:_____/_____/_____**