Otter Tail County Public Health Influenza Vaccine Form

Clear Form

Contact Information- Person being vaccinated

Last Name _____ First Name _____ MI _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip _____ Ph# _____

Immunization information may be shared through the **Minnesota Immunization Information Connection (MIIC)** with other healthcare providers, schools, health departments, and others authorized under law to receive it. If you have questions, please ask your health care provider. If you decide not to have this information shared with MIIC, please call 1-800-657-3970

Assignment of Benefits and Responsibilities for Payment: I authorize Otter Tail County Public Health Department to bill this health plan for services received and for same services to be paid directly to Otter Tail County Public Health

Payment Information

Primary Insurance Carrier: _____ t2fÙÕèlY _____ Group #: _____

Secondary Insurance Carrier: _____ Policy l: _____ Group #: _____

Cash/Check ☐ No Insurance ☐

Agreement

I have read or had explained to me the Vaccine Information Statement "Influenza Vaccine: What You Need to Know." I request that the influenza vaccination be given to me or to the person named above for whom I am authorized to make this request. I also acknowledge that a copy of the Notice of Privacy Practices has been available to me.

Signature of Patient or Legal Guardian: _____ Date:_____

Health History

Yes	No	
☐	☐	1. Are you sick today? (Fever of 100.5 or higher on the day of the clinic)
☐	☐	2. Have you ever had Guillain-Barré Syndrome within 6 weeks of an influenza vaccination?
☐	☐	3. Do you have a life-threatening allergy to eggs?
☐	☐	4. Do you have a life-threatening allergy to a component of the vaccine? May include antibiotics, gelatin or latex.
☐	☐	5. Have you ever had a reaction to a dose of flu vaccine that needed immediate medical attention?

☐ **IF YOU ARE REQUESTING TO HAVE THE *FLU MIST* PLEASE CHECK HERE AND FINISH THE FOLLOWING QUESTIONS.**

☐	☐	1. Are you or person receiving the vaccination aged 2-49?
☐	☐	2. Have you had any severe health problems that could affect your immune system, such as: Heart Disease, lung disease, asthma, kidney disease, diabetes, anemia or other blood disorder, cancer, HIV/AIDS?
☐	☐	3. Are you taking antiviral medication (like Relenza or Tamiflu)?
☐	☐	4. Are you pregnant or planning to become pregnant in the next month?
☐	☐	5. Will you have close contact with a person hospitalized for a bone marrow transplant?
☐	☐	6. Have you received MMR, MMRV, Varicella, Zoster, or Yellow Fever vaccinations in the past 4 weeks?

Vaccine Type

Place Label Here:

For Clinic Use Only

Administered By:_____

Injection Site: Deltoid Left ☐ Right ☐ Date:

Thigh Left ☐ Right ☐