

# ARKANSAS DEPARTMENT OF HEALTH INFLUENZA SEASON -- IMMUNIZATION CONSENT FORM

**For ADH use only** ADH Clinic Code: \_\_\_\_\_ School LEA #: \_\_\_\_\_ Date Of Service: \_\_\_\_\_  
 School Name: \_\_\_\_\_ School Grade: \_\_\_\_\_  State  VFC  SCHIP

**Person Receiving Vaccine:**

(Legal) First Name: \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Date of Birth:   /   /

**1. MEDICAL HISTORY:** Complete the following questions for the individual receiving the vaccine.

	YES	NO	
Have you ever had a serious allergic reaction to eggs? If yes, as a precaution, it is recommended you do not receive the flu vaccine until you have consulted your private health care provider.			If any answer is YES, you may not be able to receive the flu vaccine.
Have you ever had a serious reaction to a previous dose of flu vaccine?			
Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?			
Child's Homeroom Teacher: _____ (For school clinic use)			

**2. RELEASE AND ASSIGNMENT:**

I have read or had explained to me the Vaccine Information Statements for the Inactivated Influenza Vaccine dated 08/07/2015 and understand the risks and benefits.

I give consent to the State/Local Health Department and its staff for the individual named to be vaccinated with the flu vaccine.

I hereby acknowledge that I have reviewed a copy of the Arkansas Department of Health's Privacy Notice.

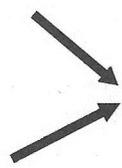
I understand that information about this flu vaccination will be included in the Arkansas Department of Health's Immunization Registry.

**To My Insurance Carrier(s):**

- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to the Arkansas Department of Health.
- I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.
- I agree that the photocopy of this form may be used instead of the original.

The Arkansas Department of Health's Privacy Notice is on the website [www.healthy.arkansas.gov](http://www.healthy.arkansas.gov), posted and available at the clinic site, or accompanies this form. Please sign on the first line in the box at right.

**Please sign here**



My signature below indicates I have read, understand and agree to section 2. **Release and Assignment** of the Influenza Season -- Immunization Consent Form.

**Signature of Patient/Parent/Guardian:**  
 \_\_\_\_\_ date \_\_\_\_\_

**Signature and Title of Vaccine Administrator:**  
 \_\_\_\_\_ date \_\_\_\_\_

**3. PATIENT INFORMATION:**

(Legal) First Name: \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth:   /   /     Gender:  Male  Female Phone #: \_\_\_\_\_

Street Address: \_\_\_\_\_ P.O. Box \_\_\_\_\_ Apt. No. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code:

Race:  White  Hispanic/Latino  Black/African-American  American Indian/Alaska Native  
 Asian  Native Hawaiian/Other Pacific Islander  Other

**4. INSURANCE STATUS (Check appropriate box):**

Patient's Relationship to Insurance Policy Holder:  Self  Spouse  Child  Other

Medicaid/ARKids Number:

Medicare Number:

Insurance Company Name: \_\_\_\_\_

Member ID/Policy #:

**REQUIRED POLICY HOLDER Information:**

(Legal) First Name: \_\_\_\_\_ MI \_\_\_\_\_ Last Name: \_\_\_\_\_

Policy Holder Date of Birth:   /   /

Policy Holder's Employer Name: \_\_\_\_\_

**Flu Vaccine Administration (Completed by ADH staff only)**

**SHOT CODE:**

- 48: Quadrivalent (P-F) 6- 35 months
- 44: Quadrivalent (P-F) ≥ 3 years

**Site Codes:** Right Arm = RA,  
 Right Leg = RL, Left Arm =  
 LA, Left Leg = LL

Flu Vaccine	Route	Site Code	Dosage mL.	Dose Number (1 <sup>st</sup> or 2 <sup>nd</sup> )	MFG Code	Lot Number	Is a 2 <sup>nd</sup> dose needed?	
	<input type="checkbox"/> IM						YES	NO

Date Vaccine Administered: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_