FLU and other VACCINE(S) DOCUMENTATION/CONSENT FORM

I have been given the information/or access to review the Vaccine Information Statement(s) (VIS) circled below. I have had the chance to read, had explained to me by the medical personal/agency, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to myself or the patient named below for whom I am authorized to make this request. I consent to inclusion of this Immunization data in the Nebraska State Immunization Information System (NESIIS) on behalf of myself or the patient named below.

Influenza MMR PCV13 VARICELLA Tdap (Td) HPV HepB HepA Other _____

PATIENT INFORMATION				
Patient's Last Name: **Patient's First Name:**		**Phone Number:**	**Age:**	**Birth Date:**
Street Address:	**City:**	**County:**	**State:**	**Zip Code:**
Phone Number: ____-_____-_____ **Gender:** _____ Male ____ Female	**Race: (Select one or more)** ___ AS-Asian/Pacific Islander/Other ___ HA-Hawaiian ___ BL-Black or African American ___ IN-Native American/Alaska Native ___ CA-Caucasian/Mexican/Puerto Rican **Ethnicity: Hispanic or Latino _____ yes _____ no**			

PATIENT ELIGIBILITY				
__ Medicaid	__No health insurance	__Underinsured*	__Native Am/Alaska Native	__Fully Insured

*Underinsured children: insurance does not cover immunizations. Eligible through VFC program if vaccinated at a FQHC, RHC, or delegated county health department.

IMMUNIZATION SCREENING QUESTIONNAIRE		
1.	Are you/or patient ill today?	__yes __no
2.	Are you/or patient allergic to eggs?	__yes __ no
3.	Have you/or patient ever had a severe reaction to any vaccine?	__yes __ no
4.	Have you/or patient had Guillian-Barre Syndrome?	__yes __ no
5.	Are you/or patient allergic to Latex?	__yes __ no
6.	Do you/or patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	__yes __ no
7.	Are you/or patient pregnant at time?	__yes __ no

I understand that, if given the flu vaccine today, it will not be fully effective for approximately two weeks. I understand that one should not receive the flu vaccine if they have had a severe allergy to eggs, a severe reaction to a previous flu vaccine, or if they have had Guillian-Barre Syndrome.

Signature of Patient or Parent/Guardian _____ **Date** _____

Manufacturer:_____ **Lot#**_____ **Exp:**_____

Dose: 0.5ml IM Injection Location: R L Deltoid Thigh

Administered by:_____ **Date:**_____