BAY AREA COMMUNITY HEALTH

Flu Consent form 2023-2024

Label	Vaccine Funding Source ☐ Purchased ☐ Vaccine For Children ☐ Vaccine For Adult ☐ State Grant Fund

Patient Name: _____
Last First Middle

Address: _____
Street Apt. # City ZipCode

Phone #: (_____)_____
Home

Date of Birth: _____ Sex at birth: ☐ Male ☐ Female
Month / Day / Year

Do you have Health Insurance? ☐ Yes ☐ No ; If yes, please provide your Health Insurance Information:

☐ Medi-Cal/Medicare ☐ Kaiser ☐ Valley Health Plan (VHP) ☐ Anthem ☐ Anthem Bluecross / Blueshield ☐ Aetna ☐ Cigna

☐ Other _____ Group Number: _____ ID Number: _____

For Patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason you or your child should not receive inactivated influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

Screening Questions	Yes	No	Maybe
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to a component of the vaccine? (Latex, Neomycin, Gelatin, Egg).	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barre syndrome which is a type of temporary severe muscle weakness, within 6 weeks after receiving a flu vaccine?	☐	☐	☐

Race and Ethnicity (Check one from each)

☐ White	☐ Asian
☐ Black or African American	☐ American Indian or Alaska Native
☐ Hispanic or Latino	☐ More than one race
☐ Native Hawaiian or Pacific Islander	☐ Refuse or decline to report

Ethnicity

☐ Hispanic/ Latino	☐ Not Hispanic/ Not Latino	☐ Refuse or decline to report

(If this consent form is not signed, patient will not be vaccinated)

I have read or had explained to me the Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits. I give consent to Bay Area Community Health Center to administer the Flu Vaccine.

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Patient's (If minor- guardian or parent) Signature _____ *Date* _____

Provider Fill out the Following:

Age	Dosage	Provider Initial
Child 6 months - 35 months old (2 doses 4 weeks apart if they are receiving the Flu vaccine for the first time)	0.25 mL	
Children 6 months to 8 years old (2 doses 4 weeks apart if they are receiving the Flu vaccine for the first time)	0.5 mL	
Children 9 years and older receive 1 dose	0.5 mL	
Pregnant Patients- preservative FREE	0.5 mL	

Second dose recommended ☐ Yes ☐ No ICD 10: Z 23

Ordering Provider: _____ *Date:* _____

MA, select appropriate vaccine to be administered. Please enter Flu vaccine if not on the list.

CPT Code / Funding Source	Lot Number	Vaccine type	Manufacturer Indication	Exp. Date

Injection Site: Right deltoid Left deltoid right vastus lateralis left vastus lateralis

Signature and title of Vaccine Administrator: _____

Date: _____