CASCADE CITY-COUNTY HEALTH DEPARTMENT
INFLUENZA CLINIC - CONSENT AND REGISTRATION FORM

If you print this at home and bring to a walk-in clinic, you will NOT be given a copy of the final signed form at the clinic. Please call or visit our office the following business day for a copy.

Client Information (please print legibly - a staff member may assist if you prefer)

Legal Name		**DOB**	**Legal Gender** F M
Address	**City**	**State**	**Zip**

Phone Number	**Ethnicity**	**Race (select all that apply)**	
	Hispanic Origin	Native American/Alaskan	Asian
Cell Number	Non-Hispanic Origin	African American/Black	White
	Prefer Not To Say	Native Hawaiian/Pacific Islander	Other

Clinic Use ONLY

Insurance company ______________________ Subscriber ID ______________________

Group # ______________ Payer ID ______________

VFA VFC Insured (Private Pay)

$_______Cash $_______Check Amount ________Check Number $________Credit Card

I have read the influenza vaccine information and questions have been answered to my satisfaction. My signature below indicates I consent to the vaccine without coercion or reservation. I also give consent for vaccination information to be entered into an electronic data base. I understand I can revoke this authorization and have my record removed at any time by contacting my local health department. By signing this form, I confirm that I have been offered a copy of the City-County Health Department (CCHD) *Notice of Privacy Practices* and have had my questions about the Notice answered to my satisfaction.

For Medicare, Medicare Advantage, Medicaid, CHIP or other insurance claims, I authorize the release of any medical or other information necessary to process this claim. I also assign payment of benefits to the CCHD. **I agree to be financially responsible for any fees not covered by the insurance noted above.**

X______________________________ ______________________________ ______________

Signature of Vaccine Recipient or Guardian **(If Guardian, Please Print Name Here)** **Date**

Vaccine Administration Information

What is your age?	________	
Are you allergic to eggs, poultry, thimerosal, or latex?	Yes	No
Are you pregnant?	Yes	No
Have you had any previous reaction to flu vaccine?	Yes	No
Have you ever been diagnosed with Guillain-Barre' syndrome/paralysis?	Yes	No
Are you currently experiencing any moderate or severe illness?	Yes	No

Site ______________________ Lot # and expiration date ______________________

VIS Date: ______________________ ______________________

Vaccinator Signature Date