Franklin County Public Health
280 East Broad Street
Columbus, Ohio 43215-4562
(614) 525-3160
www.myfcph.org

Flu Consent/Administration Form

Immunization Program

Office Use Only	Date:
	Location:

Person Receiving Vaccination

First Name	MI	Last Name		
Address	City		State	Zip
Phone ( )	Age		Date of Birth	

Race (check all that apply):
□ Asian □ Black/African American □ White □ Native American or Alaskan Native □ Other_____

Ethnicity	Gender
□ Hispanic or Latino □ Non-Hispanic or Latino	□ Male □ Female

Parent/ Legal Guardian (if applicable)

First Name	Last Name
Relationship to Child	Phone ( )

Screening Questions for Person Receiving Vaccine

1. Are you sick today?	□ Yes □ No
2. Have any allergies? Especially to latex, gelatin, chicken eggs/feathers? ***If YES, please list allergies:**	□ Yes □ No
3. Any serious reaction to influenza vaccine in the past?	□ Yes □ No
4. Ever had Guillain-Barré syndrome?	□ Yes □ No

Insurance Information

□ None □ Name of Insurance: Insurance Member ID :

Consent for Treatment

To the best of my knowledge, I understand the benefits and/or risks of vaccines. I hereby give consent to Franklin County Public Health (FCPH) staff for the administration of the vaccine to myself or for the individual for whom I am authorized to make said request. I have received a copy of the most up-to-date Vaccine Information Statement (VIS). I understand that I will have the chance to ask questions and have them answered to my satisfaction. I acknowledge that I have been offered and/or received the FCPH Notice of Privacy Practice Summary (HIPPA), which explains policies concerning my personal health information. FCPH is authorized to release vaccination information to schools, day cares, and/or others as necessary or required for treatment of care and billing purposes.

Signature: **Date**:

For Staff Use Only: **Medical Screener Signature**: ☐ Criteria NOT MET

☐ **6 months – 35 months** ☐ Left Thigh ☐ Right Thigh
Age _____ ☐ Pediatric 0.25ml (90685) ☐ Lot #_____ ☐ IM ☐ Left Deltoid ☐ Right Deltoid

☐ **3 years – 64 years** ☐ Left Thigh ☐ Right Thigh
Age _____ ☐ 0.5 ml (90686) ☐ Lot #_____ ☐ IM ☐ Left Deltoid ☐ Right Deltoid

☐ **65 years and up**
Age _____ ☐ 0.5 ml **High Dose** (90662) ☐ Lot #_____ ☐ IM ☐ Left Deltoid ☐ Right Deltoid

Vaccinator Signature: **Date**: VIS 08/07/2015

Official VFC Status:
□ ADULT - N □ Privately insured - N □ Fed. Eligibility (Underinsured) - Y □ Medicaid - Y □ Uninsured - Y □ AI/AN - Y

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