Flu Vaccination Consent Form 2020 - 2021

Last Name | **First Name** | **MI**

Home Address (House Number and Street Name) | **Apt Number**

City | **Zip Code** | **Gender** ○ Male ○ Female

Patient's Mother's First Name Only

Patient's Date of Birth (example 05/22/1982) ___ / ___ / ___

Area Code **Phone Number** ___ - ___ - ___

Patient's Age | **Infant (Months)**

Race/Ethnicity (Choose One) ○ Asian ○ Black/African American ○ Hispanic/Latino ○ White ○ Native Hawaiian/Pacific Islander ○ American Indian/Alaskan Native ○ Multi-Race ○ Other

Housing Status: Are you currently experiencing homelessness? ○ Yes ○ No

What type of health insurance do you have? (Check all that apply)

○ None ○ Private (ex. Anthem Blue Cross, Kaiser Permanente)

○ Medi-Cal/Medicaid ○ Medicare ○ I don't know ○ Other insurance: ____________

Question		
1. Are you sick or experiencing any symptoms of COVID-19 (i.e. cough, fever, loss of taste/smell)?	○ Yes	○ No
2. Are you pregnant or do you think you may be pregnant?	○ Yes	○ No
3. Have you had a serious reaction to flu vaccine requiring medical help?	○ Yes	○ No

I CONSENT TO THE VACCINATION PROVIDED | If under 18 years of age, PRINT name of parent or legal guardian

STOP - DO NOT WRITE BELOW THIS LINE **SCREENER INITIALS**

Question			
4. Do you have a severe allergy to eggs?	[If YES, See Allergy Guidelines]	○ Yes	○ No
5. Do you have an allergy to thimerosal?		○ Yes	○ No
6. Do you have any of the following conditions? Heart, Lung, Kidney or Liver Disease; Asthma; Cancer; Metabolic disease (i.e. diabetes); Blood Disorders (i.e. leukemia, lymphoma, sickle cell disease); Immune System Disorder (i.e. HIV/AIDS, steroid therapy)	[If YES, IIV indicated]	○ Yes	○ No
7. Have you ever had Guillain-Barré Syndrome (GBS)?		○ Yes	○ No

Manufacturer and Lot Number **Flu Vaccine VIS (IIV) 08/15/2019**

INACTIVATED (Flu Shot - IIV)

Manufacturer ○ GSK ○ SP ○ Other________

Lot #

Dose ○ 1 ○ 2 | **Dosage** ○ 0.50mL | **Site** ○ LD ○ RD ○ LT ○ RT

Date Administered (MM/DD/YYYY) (example 10/20/2019) ___ / ___ / ___

PLEASE PRINT CLEARLY

Admin Initials:

Language Interpreter Signature: | Nurse Instructor Signature:

English

Los Angeles County Health Agency

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

Effective Date: May 30, 2017

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of the Los Angeles County (LAC-Health Agency) Departments of Health Services, Mental Health, and Public Health, collectively referred to as the Health Agency. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

I acknowledge receipt of the *Notice of Privacy Practices* of LAC-Health Agency.

Signature:____Date: __________________

(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Workforce Member: ________________________________ Date: ______________

Reasons why the acknowledgement was not obtained:

☐ Patient refused to sign.

☐ Other Reason or Comments:

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