ADULT INFLUENZA
IMMUNIZATION CONSENT AND HISTORY

Livingston County Health Center
800 Adam Drive Chillicothe, MO 64601

Last Name	First Name	MI	Male/Female	Date of Birth

Street Address	City	State	Zip Code	Phone	Age

Race

☐ White
☐ Black
☐ Alaskan/Native American
☐ Asian
☐ Hawaiian/Pacific Islander
☐ Hispanic/Latino
☐ Bi Racial or Multi Racial

Ethnicity

☐ Non-Hispanic
☐ Cuban
☐ Mexican
☐ Central/South American
☐ Puerto Rican
☐ Other

Insurance Information

☐ **Medicare*** ☐ **MoHealth/Medicaid** ☐ **Private Insurance** ☐ **I Am Uninsured**

Does your insurance pay for vaccinations? ☐ No ☐ Yes

***Medicare Number:** _____

Vaccine Information Statements

☐ Influenza 8-06-2021 ☐ Influenza (Live) 8-06-2021

I have been given a copy of and have read, or had explained to me, the information in the **"Vaccine Information Statements"** for the vaccines indicated above. I understand the benefits and risks of the vaccines and ask that the vaccines be given to me or the person named above for whom I am the authorized to make this request pursuant to Section 431.058,RSMo. **VIS Date 08/06/2021**

I authorize payment of Medicare claim to the Livingston County Health Center; and release of medical information to process this claim.

X_____

Authorized Signature Relationship Date

ALL SERVICES PROVIDED ON A NON DISCRIMINATORY BASIS

MODIFIED 09/16/21

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please as a nurse to explain it.

	yes	no	don't know
1. Are you sick today?	○	○	◉
2. Do you have an allergy to a component of the vaccine?	○	○	◉
3. Have you ever had a serious reaction to influenza vaccine in the past?	○	○	◉
4. Have you ever had Guillain-Barre syndrome?	○	○	◉

FORM COMPLETED BY: (PLEASE PRINT) _____ DATE _____

VACCINE:				
MFR/LOT EXP DATE				
SITE SIGNATURE	L	R	IM	DELTOID NASAL

X_____

Signature/Title Vaccine Administrator Date Administered/VIS Given