ST. FRANCOIS COUNTY HEALTH CENTER 1025 W. MAIN ST PARK HILLS, MO 63601

FLU FORM

(Please Print)

Today's date:	SFCHC Staff:

PATIENT INFORMATION

Patient's name Last, First, Middle:		
Address (street , city) **County**		**Social Security Number**
Parent/Guardian name **Mother's Name Last, First, Middle**	**Sex:** ❑ **M** ❑ **F**	**Race (please circle):** White AA/Black Indian Asian Other Hispanic Alaskan Native American
Father's name Last, First, Middle	**Phone Number (home)**	

Medicaid: Yes No
Number _____ Plan (Please Circle) Aetna Home State MOCare NoPlan

Medicare: Yes No
Medicare Number: _____

Private Insurance: Yes No
Name of Insurance Company_____

Policy Holder's Name _____ D.O.B_____

ID #_____ Group#_____

Secondary/Supplement Insurance: Yes No
Name of Insurance Company_____

Policy Holder's Name _____ D.O.B_____

ID #_____ Group#_____

Does the person receiving the vaccine have any of the following:	**YES**	**NO**
1. A serious allergy to eggs?		
2. Any other serious allergies that you know of? Please list:		
3. Had a fever in the last 24 hours?		
4. Had a serious reaction to a previous dose of flu vaccine? Intranasal Injectable		
5. Had Guillain-Barre Syndrome (a severe form of paralysis) within 6 weeks of receiving a flu vaccine?		
6. Pregnant or currently breastfeeding?		

CONSENT FOR VACCINATION

I have read or had explained to me the "Influenza Vaccine Information Statement" and understand the risks and benefits of the vaccine(s). I have had a chance to ask questions and had them answered to my satisfaction. I have signed below for the patient named above for whom I am authorized to make this request pursuant to Section 431.058, RSMo to receive the influenza vaccination.

PLEASE PRINT PATIENT NAME: _____**DATE:** _____

PATIENT/PARENT/GUARDIAN SIGNATURE: _____**DATE:** _____

STAFF SIGNATURE: _____

CONSENT FOR SECOND DOSE VACCINATION

PLEASE PRINT PATIENT NAME: _____**DATE:** _____

PATIENT/PARENT/ GURADIAN SIGNATURE: _____ **DATE:** _____

STAFF SIGNATURE: _____

CONSENT to SHARE HEALTH CARE INFORMATION

The above information is true to the best of my knowledge. I give my consent for information contained on this form to be released to medical or billing entities by the St Francois County Health Center and to share health information about the above named client with participating providers when appropriate in order to provide the above named client treatment or health related services including the Chronic Disease and/or Diabetes Self-Management Classes or other Dietitian services or Health Education services, as well to be contacted by them. I understand that the confidentiality of the information will be maintained as required by applicable state and federal laws. I have been informed of St Francois County Health Center's HIPAA information regarding Notice of Privacy Practices. I understand information will not be given to care providers that have not signed an agreement with St. Francois County Health Center or be used for any other purpose except in an aggregate form without my specific permission. Finally, I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization is not required to agree to restrictions requested. This consent remains in effect unless I give written notice to revoke. I understand my refusal to give permission will not influence the services I receive.

PLEASE PRINT PATIENT NAME: _____DATE: _____

PATIENT/PARENT/GUARDIAN SIGNATURE: _____DATE: _____

CONSENT to SHARE HEALTH CARE INFORMATION

PLEASE PRINT PATIENT NAME: _____**DATE:** _____

PATIENT/PARENT/ GURADIAN SIGNATURE: _____ **DATE:** _____

FOR STAFF USE ONLY

VACCINE	M/D/Y	SITE	MANUFACTURER	LOT NUMBER	EXPIRATION	Vaccine Administered by
INFLUENZA **INJECTABLE**		**L R THIGH DELTOID**	GSK	4ES32	5/31/18	
INFLUENZA **INJECTABLE**		**L R THIGH DELTOID**				