Louisiana Academic Health

School Clinic Name:_____

School Term:_____

INFLUENZA VACCINE CONSENT & ADMINISTRATION RECORD

PATIENT INFORMATION

Full Name:_____ Date of Birth:_____

Email Address:_____ Phone #:_____

Payment Method: ☐ Cash ☐ Insurance

Insurance Company Name:_____ Policy Holder Name:_____

Relationship:_____ Policy #_____ Group #_____

Screening Questions:

1. Are you sick today? (For example: a cold, fever, or acute illness)
   ☐ YES ☐ NO ☐ DON'T KNOW

2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (for example: eggs, gelatin, neomycin, thimerosal, etc.) List
   ☐ YES ☐ NO ☐ DON'T KNOW *Allergies:* _____

3. Do you take anticoagulation medication? (For example: warfarin, Coumadin or other blood thinner)
   ☐ YES ☐ NO ☐ DON'T KNOW

4. Do you have a long-term health problem with heart disease, lung diseases, asthma, kidney disease, metabolic diseases (e.g. diabetes), anemia or other blood disorder?
   ☐ YES ☐ NO ☐ DON'T KNOW

5. Have you had a seizure, brain or other nervous system problem? (For example: Guillain-Barre syndrome)
   ☐ YES ☐ NO ☐ DON'T KNOW

6. For women: Are you pregnant or nursing? Could you become pregnant during the next month?
   ☐ YES ☐ NO ☐ DON'T KNOW

VACCINE ADMINISTRATION INFORMATION

Administrative Date:_____ Time:_____

Vaccine:_____ Manufacturer:_____ Lot#:_____

Exp. Date:_____ Dose Given:_____ Injection Site:_____

_____

VACCINE ADMINISTRATOR SIGNATURE & DATE

CONSENT FOR SERVICES & MEDICAL RECORDS INFORMATION

CONSENT FOR SERVICES: I have been provided with the Vaccine Information Sheet corresponding to the vaccine(s) that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risk of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or to the person named above for whom I am authorized to make this request.

AUTHORIZATION TO REQUEST PAYMENT: I do hereby authorize LAHN to release information and request payment. I certify that the information given by me in applying for payment under Medicare is correct. I authorize release of all records to act on this request. I request that payment of authorized benefits be made on my behalf.

HIPPA AUTHORIZATION: I voluntarily authorize and direct my health care provider at LAHN to use and to disclose my health information to the physician responsible for this protocol of specific health information of people vaccinated at LAHN, my Primary Care Physician, my insurance plan, health systems and hospitals, and/or state or federal registries, where required, for purposes of treatment, payment or other health care operations (such as administration or quality assurance) during the term of this HIPPA Authorization. This Authorization permits LAHN to disclose only documents related to the recipients identified today. This Authorization will remain in effect until my health information is disclosed to the recipients identified above. LAHN cannot guarantee that any recipient will not re-disclose my health information to a third party that may not be required to abide by this Authorization or applicable federal and revoke (at any time) this Authorization for any reason and that such a refusal or revocation will not affect the commencement, continuation or quality of my treatment by LAHN. I understand that this Authorization will remain in effect until the term of this Authorization expires as noted above or provided a written notice of revocation to LAHN to the address provided in the LAHN Notice of Privacy Practices. The revocation will be effective immediately upon LAHN receipt of my written notice, except that the revocation will not have any effect on any action taken by LAHN in reliance on this Authorization before it received my written notice of revocation.

X _____ Date _____

Signature of patient to receive vaccine or person authorized to make the request (Parent/Guardian)