Vaccine Informed Consent (Flu)

COMMUNITY HEALTH ALLIANCE

Patient Information

First Name: _____ Last Name: _____

Date of Birth: _____

Age: _____

Street: _____

City: _____ Zip Code: _____ Phone: _____ **Circle one**: Male Female

Insurance Information

Insurance Name: _____ BIN Number: _____

Medicare Beneficiaries:

SSN: _____

ID Number: _____ Group Number: _____

☐ I do not have insurance at this time.

I, the undersigned, have read or had explained to me the vaccination information sheet (VIS). I understand the risks and benefits associated with the vaccine(s) and have had my questions answered to my satisfaction. I voluntarily request that the vaccine be given to me or for the aforementioned person for whom I am authorized to make this request. By signing this form, I am indicating that I understand that I can access a copy of Community Health Alliance's Notice of Privacy Practices related to health information by visiting https://www.chanevada.org/patients/privacy-policy.

☐ I authorize the vaccine to be administered by a trained student pharmacist.

Signature: _____ Date: _____

Print name of parent, guardian or caregiver: _____

Screening Questionnaire			
	Yes	**No**	**Unknown**
Are you currently ill or do you have a fever?	☐	☐	☐
Have you ever received the flu vaccine before?	☐	☐	☐
Have you ever had a serious reaction to a vaccine before?	☐	☐	☐
Do you have an allergy to eggs or to any component of a vaccine?	☐	☐	☐
Have you received any vaccines in the last 4 weeks?	☐	☐	☐
For women: Are you currently pregnant?	☐	☐	☐

Brand/Manufacturer	Lot	Expiration	Dose	Site (RD, LD)	Pharmacist

☐ Entered into WebIZ

Funding: : ☐ 317 ☐ VFC ☐ Private

Last updated: November 2022