ARKANSAS DEPARTMENT OF HEALTH
INFLUENZA SEASON -- IMMUNIZATION CONSENT FORM

For ADH use only
ADH Clinic Code: _______________ School LEA #: _______________ Date Of Service: __________

School Name: ___________________________ School Grade: ______

Person Receiving Vaccine:
(Legal) First Name: ______________________ MI ____ Last ______________________
Date of Birth: __________ / __________ / __________

1. MEDICAL HISTORY: Complete the following questions for the individual receiving the vaccine.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had a serious allergic reaction to eggs? If yes, as a precaution, it is recommended you do not receive the flu vaccine until you have consulted your private health care provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had a serious reaction to a previous dose of flu vaccine?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Child’s Homeroom Teacher: ________________________________ (For school clinic use)

2. RELEASE AND ASSIGNMENT:

I have read or had explained to me the Vaccine Information Statements for the Inactivated Influenza Vaccine dated 08/07/2015 and understand the risks and benefits.

I give consent to the State/Local Health Department and its staff for the individual named to be vaccinated with the flu vaccine.

I hereby acknowledge that I have reviewed a copy of the Arkansas Department of Health’s Privacy Notice.

I understand that information about this flu vaccination will be included in the Arkansas Department of Health’s Immunization Registry.

To My Insurance Carrier(s):
- I authorize the release of any medical information necessary to process my insurance claim(s).
- I authorize and request payment of medical benefits directly to the Arkansas Department of Health.
- I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.
- I agree that the photocopy of this form may be used instead of the original.

The Arkansas Department of Health’s Privacy Notice is on the website www.healthy.arkansas.gov, posted and available at the clinic site, or accompanies this form. Please sign on the first line in the box at right.

My signature below indicates I have read, understand and agree to section 2. Release and Assignment of the Influenza Season -- Immunization Consent Form.

Signature of Patient/Parent/Guardian: ___________________________ date __________

Please sign here
3. PATIENT INFORMATION:

(Legal) First Name: _________________________ MI ____ Last Name: __________________________

Date of Birth: _______ / _______ / _______ Gender: ☐ Male ☐ Female Phone #: __________________________

Street Address: ___________________________________________ P.O. Box _________ Apt. No. ________

City: ___________________________ State: __________ Zip Code: __________

Race: ☐ White ☐ Hispanic/Latino ☐ Black/African-American ☐ American Indian/Alaska Native
☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other

4. INSURANCE STATUS (Check appropriate box):

Patient’s Relationship to Insurance Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

☐ Medicaid/ARKids Number: _____________________________

☐ Medicare Number: _____________________________

☐ Insurance Company Name: __________________________________________

Member ID/Policy #: __________________________________________

REQUIRED POLICY HOLDER Information:

(Legal) First Name: _________________________ MI ____ Last Name: __________________________

Policy Holder Date of Birth: _______ / _______ / _______

Policy Holder’s Employer Name: __________________________________________

5. Flu Vaccine Administration

SHOT CODE:

☐ 70: FluLaval Quadrivalent (P-F) ≥ 6 Months

Do Not Use Codes Below Unless Instructed

☐ 48: Quadrivalent (P-F) 6- 35 months
☐ 44: Quadrivalent (P-F) ≥ 3 years

<table>
<thead>
<tr>
<th>Flu Vaccine</th>
<th>Route</th>
<th>Site Code</th>
<th>Dosage mL</th>
<th>Dose Number (1st or 2nd)</th>
<th>MFG Code</th>
<th>Lot Number</th>
<th>Is a 2nd dose needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ IM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>YES</td>
</tr>
</tbody>
</table>

Signature and Title of Vaccine Administrator: __________________________________________

Date Vaccine Administered: _______ / _______ / _______

Site Codes: Right Arm = RA, Right Leg = RL, Left Arm = LA, Left Leg = LL