Georgia Department of Public Health
District 4 Public Health

COMPLETE ALL INFORMATION

Spalding County Health Department

2023-2024 Flu Vaccine Consent Form

Legal Name Only - Please Print in blue or black ink only. (No pencil)

Last name_____

First name _____Middle Name_____

Date of birth _____ Age _____ Race _____

Male / Female Home/Cell number _____

Address _____

City_____ Zip code_____

Emergency Contact: (Parent/Guardian)

Name _____Number _____

Georgia Medicaid # _____

Amerigroup, Medicaid/PeachCare, Peach state, CareSource

Circle Insurance coverage

Aetna / Cigna / Coventry / Blue Cross Blue Shield/ United Health Care/Medicare/UMR

Policy # _____

Policy Holder Name _____

Policy Holder Social Security #:_____

Policy Holder Date of Birth _____

**We will make every effort to bill your insurance company. If claim is denied, a bill and copy of the EOB will be mailed to you.*

*Other insurance coverage not listed above, the cost will be $30.00. High dose and Flublok are $75.00.

*No insurance for a child will be $21.93.

PLEASE ANSWER ALL QUESTIONS

Please check if any of the following restrictions apply to the person receiving the Flu vaccine:

_____ Is this person sick today?

_____Serious allergy to eggs, medication, gelatin or another vaccine component?

_____Ever had a serious reaction to previous dose of flu vaccine that required medical attention?

_____History of Guillain-Barre Syndrome (temporary severe muscle weakness) after receiving flu vaccine?

_____Received any vaccines in the last 30 days?

_____Any allergy to Latex?

_____Pregnant?

_____**NONE OF THE ABOVE**

Consent for Seasonal Influenza Vaccine

_____ YES, I want give consent for the influenza vaccine.

I have received, read, and understand the CDC Vaccine Information Statement (8/6/2021) for the 2023-2024 Influenza Vaccine. I have had the opportunity to ask questions and understand the benefits and risks of the flu vaccine. I request and voluntary consent that the flu vaccine be given to the person above. I authorize the release of information from public health as required by law, for data collection and filing of claims for reimbursement directly from Medicaid or my insurance provider if applicable. I am aware of the need to remain at the clinic for 30 minutes after receiving an injection.

Patient/Legal Guardian Signature: _____

Inactivated Vaccine _____ **Lot #** _____ **Expiration** _____

Live/Activated Vaccine _____ **Lot #** _____ **Expiration** _____

Nurse Signature: _____ **Date:** _____