NIOBRARA VALLEY HOSPITAL MEDICAL CLINIC

FLU VACCINE CLINIC

Boyd County School

7:00am to 8:15am on scheduled days

Name: (Last)_____________________(First)_________________(Middle)____________________

Date of Birth:_____________________

Physical Address_________________________City___________________State_____Zip_________

Mailing Address(if different)_________________________City____________State_____Zip_______

Phone: Home_______________________ Cell________________________

PARENT/GUARDIAN INFORMATION (if under 19 years of age)

Name(last)___________________________(first)_______________________(middle)__________

Date of Birth:______________________

INSURANCE INFORMATION

We will need a copy of your Insurance Card

Insurance Name:____

Policy Holder Name:____DOB:____________

Our clinic participates in the Nebraska Vaccines for Children Program. If your child qualifies for Medicaid, we are able to offer them either the flu shot or flu mist (nasal spray).

If your child qualifies, please choose an option: _____Flu Shot or _____*FluMist (nasal spray)

**We have limited quantities of FluMist on hand. It will given on a first come, first serve basis.*

*PLEASE NOTE: Children under the age of 12 must be accompanied by an adult.

FLU VACCINE QUESTIONNAIRE AND CONSENT

Name:____Date of Birth:_______________Age:_______

Please answer the following questions:

Do you have an allergy to eggs or poultry?	yes	no
Do you have any allergies to medications?	yes	no
Have you received the flu vaccine in the past?	yes	no
If yes, what was the approximate date of last dose?____________________		
Have you ever had a reaction or problem with a flu vaccine?	yes	no
Were you ever paralyzed by Guillan-Bare Syndrome?	yes	no
Do you or a family member currently have a moderate or severe illness?	yes	no
Did you receive a Vaccine Information Statement?	yes	no

By signing below, I acknowledge the following: I have read the information in the "Vaccine Information Statement" on the Influenza vaccine. I understand the risks and benefits associated with the influenza vaccination, and my questions have been answered. I wish to receive the influenza vaccine.

*Signature:____ Date:__________________

(*must be signed by parent if under 19 years of age)

******For office use only******

☐ Fluzone Trivalent Sanofi Pasteur	☐ Fluzone High Dose Sanofi Pasteur	☐ **VFC** Fluzone Tri Sanofi Pasteur	☐ **VFC** FluMist Tri Medimmune, Inc.
49281-0641-78	49281-124-88	49281-0424-88	66019-0311-00
Lot: U8435AA	Lot: U8130AA	Lot: UT8423NA	Lot: WF2582
Exp: 06/30/2025	Exp: 06/30/2025	Exp: 06/30/2025	Exp: 12/09/2024
Dose: 0.5mL	Dose: 0.5mL	Dose: 0.5mL	Dose: 0.2mL

Circle site information: Left or Right Thigh or Deltoid Intranasal

Administering Clinician:____Date:___________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed and outlines my rights with respect to such information. I understand that I should read it carefully.

I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 402-569-2451 or by requesting one at Niobrara Valley Hospital.

Patient Name____ Date_________________

Signed/Verbal Acknowledgement given by____

If verbal consent given, (2) witness signatures:____