



Franklin County Public Health  
280 East Broad Street  
Columbus, Ohio 43215-4562  
(614) 525-3160  
www.myfcph.org

## Flu Consent/Administration Form

Immunization Program

Office Use Only	Date:
	Location:

### Person Receiving Vaccination

First Name	MI	Last Name	
Address	City		State Zip
Phone ( )	Age		Date of Birth
Race (check all that apply): <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native American or Alaskan Native <input type="checkbox"/> Other _____			
Ethnicity <input type="checkbox"/> Hispanic or Latino	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		

### Parent/ Legal Guardian (if applicable)

First Name	Last Name	
Relationship to Child	Phone ( )	

### Screening Questions for Person Receiving Vaccine

1. Are you sick today?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have any allergies? Especially to latex, gelatin, chicken eggs/feathers? <b>*If YES, please list allergies:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Any serious reaction to influenza vaccine in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Ever had Guillain-Barré syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Insurance Information

<input type="checkbox"/> None <input type="checkbox"/> Name of Insurance:	Insurance Member ID :
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### Consent for Treatment

To the best of my knowledge, I understand the benefits and/or risks of vaccines. I hereby give consent to Franklin County Public Health (FCPH) staff for the administration of the vaccine to myself or for the individual for whom I am authorized to make said request. I have received a copy of the most up-to-date Vaccine Information Statement (VIS). I understand that I will have the chance to ask questions and have them answered to my satisfaction. I acknowledge that I have been offered and/or received the FCPH Notice of Privacy Practice Summary (HIPPA), which explains policies concerning my personal health information. FCPH is authorized to release vaccination information to schools, day cares, and/or others as necessary or required for treatment of care and billing purposes.

**Signature:**

**Date:**

<b>For Staff Use Only: Medical Screener Signature:</b>		<input type="checkbox"/> Criteria NOT MET
<input type="checkbox"/> <b>6 months – 35 months</b>		
Age _____	<input type="checkbox"/> Pediatric 0.25ml (90685)	<input type="checkbox"/> Lot # _____ <input type="checkbox"/> IM <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid
<input type="checkbox"/> <b>3 years – 64 years</b>		
Age _____	<input type="checkbox"/> 0.5 ml (90686)	<input type="checkbox"/> Lot # _____ <input type="checkbox"/> IM <input type="checkbox"/> Left Thigh <input type="checkbox"/> Right Thigh <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid
<input type="checkbox"/> <b>65 years and up</b>		
Age _____	<input type="checkbox"/> 0.5 ml <b>High Dose</b> (90662)	<input type="checkbox"/> Lot # _____ <input type="checkbox"/> IM <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid

<b>Vaccinator Signature:</b>	<b>Date:</b>	VIS 08/07/2015
<b>Official VFC Status:</b>		
<input type="checkbox"/> ADULT - N <input type="checkbox"/> Privately insured - N <input type="checkbox"/> Fed. Eligibility (Underinsured) - Y <input type="checkbox"/> Medicaid - Y <input type="checkbox"/> Uninsured - Y <input type="checkbox"/> AI/AN - Y		