FAMILY CARE
SPOKANE

RETURN COMPLETED FORM AND COPY OF PATIENT INSURANCE CARD FRONT & BACK.

FLU VACCINE SCREENING QUESTIONNAIRE AND CONSENT FORM

Patient Information: (Patient to complete)

Patient Name :	Date of Birth:	Age:	Phone:
Address:	City:	State:	Zip:
Email Address:			
Medical Conditions:		Enter weight if less than 110 lbs.	
Primary Care Physician:		Dr. Phone:	
PCP Address:	City:	State:	Zip:
Insurance Company:			

Flu Dose being Requested ☐ Regular ☐ High (seniors and other identified populations)

The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask our clinical team to explain it.	YES	NO	Don't Know
Are you sick today?	☐	☐	☐
Do you have a long term health problem with heart disease, kidney disease, metabolic disorder (e.g. diabetes), anemia, or other blood disorders?	☐	☐	☐
Do you have a long term health problem with lung disease or asthma? Do you smoke?	☐	☐	☐
Do you have allergies to medications, food (i.e. eggs), latex or any vaccine component (e.g. neomycin, formaldehyde, gentamicin, thimerosal, bovine protein, phenol, polymyxin, gelatin, baker's yeast, or yeast)?	☐	☐	☐
Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
Do you have a neurological disorder such as seizures or other disorders that affect the brain or have had a disorder that resulted from a vaccine (e.g. Guillain-Barre Syndrome)?	☐	☐	☐
Do you have cancer, leukemia, AIDS, or any other immune system problems? (in some circumstances you may be referred to your physician)	☐	☐	☐
Do you take prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
During the past year, have you received a transfusion of blood or blood products, including antibodies?	☐	☐	☐
Are you a parent, family member or caregiver to a newborn infant?	☐	☐	☐
For Women: Are you pregnant or could you become pregnant in the next 3 months?	☐	☐	☐
Did you bring your Immunization Record Card with you?	☐	☐	☐

I authorize the release of any medical or other information with respect to this vaccine to my healthcare providers, Medicare, Medicaid or other third party payer as needed and request payment of authorized benefits to be made on my behalf to Family Care Spokane.

- I acknowledge that if my insurance does not cover the cost of administering the vaccine, then payment must be made at the time of the administration of the vaccine.

- I acknowledge that my vaccination record may be shared with federal or state or city agencies for registry reporting.
- I have been informed of emergent allergic reaction including, Skin flushing, itching; Respiratory symptoms, including nasal discharge, nasal congestion, change in voice quality, sensation of throat closure or choking, stridor, cough, wheeze, and shortness of breath; Cardiovascular symptoms, including faintness, fainting, altered mental status, heart palpitations, and will seek immediate assistance by calling 911.
- I acknowledge receipt of Notice of Privacy Practices for Protected Health Information.
- I acknowledge that the administration of an immunization or vaccine does not substitute for an annual check-up with the patient's primary care physician.
- I certify my receipt of the services covered by this claim. I request that payment be made on my behalf. I authorize the holder to release medical information about me to any party involved in payment or their agents.
- I have read, or have had read to me, the Vaccination Information Sheet (VIS) regarding the vaccine. I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine. I consent to or give consent for, the administration of the vaccine. I fully release and discharge, the clinic for any liability for illness, injury, loss or damage which may result therefrom.

Patient Signature, or legal guardian signature: _____

If legal guardian, print name: _____

CLINICAL USE ONLY

Please Rx Label Here

Exp. Date _____

Site: ☐ RA ☐ LA

Signature of clinical member who administered vaccination and provided VIS to patient: _____

Team member title: _____

Publication Date of VIS: _____

Date VIS Given to Patient: _____

Provider License #_____ NPI #_____

Reviewed 9/21/2020