

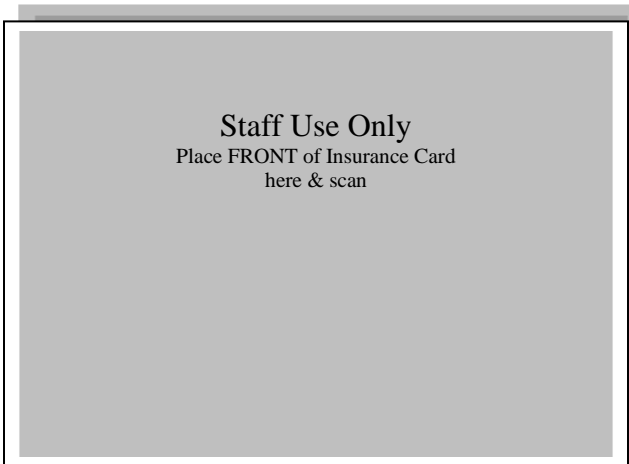


Harrison County General Health District

Seasonal Influenza **High Dose** Vaccine Consent

PATIENT'S NAME: (Last)	(First)	(M.I.)	PATIENT'S DATE OF BIRTH:
PATIENT'S ADDRESS:			PATIENT'S GENDER:
			<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE
CITY:	STATE:	ZIP:	PHONE:

Please Answer the Following Questions:	YES	NO
Is the patient 65 or older?	<input type="checkbox"/>	<input type="checkbox"/>
Is this the patient's very first influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever had a serious reaction to a previous dose of flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient ill with fever today?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have a serious allergy to eggs?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have an allergy to latex?	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever had Guillain-Barré Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient taking blood thinners or at risk for bleeding?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient have any other medical condition causing lower immunity?	<input type="checkbox"/>	<input type="checkbox"/>



Insurance Provider:	YES	NO
Is the patient covered by Medicare or Medicaid?	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient self-paying?	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient qualify for an ODH supplied vaccine?	<input type="checkbox"/>	<input type="checkbox"/>



Form Continued Next Other Side ⇨

