



Information about person to be vaccinated (please print)

Complete a form for each patient

Last Name: _____ Age: _____

First Name: _____ Sex: ____ M ____ F

Date of Birth: _____ Phone #: _____

Mailing Address: _____ City: _____ Zip _____

For child - Please Print

Parent's Name: _____

Parent/Guardian address if different than above: _____

INSURANCE Status

- Insurance
- Medicaid
- No Insurance
- Insurance that DOES NOT cover vaccines
- American Indian or Alaskan Native (VFC Eligible)

Insurance Information

Name of Policy Holder: _____ RXGRP: _____
 Policy Holder Date of Birth: _____ Insurance Address: _____
 Relationship: _____ Insurance Address: _____
 Policy ID: _____ Insurance Phone: _____
 Group: _____
 RXBIN: _____
 RXPCN: _____

Please answer the following for the person to be vaccinated.

- | | Yes | No | Dont know | |
|---|------------|-----------|------------------|----------|
| 1. Is the person sick today? | ___ | ___ | ___ | temp:___ |
| 2. Does the person have an allergy to eggs or to a component of the vaccine? | ___ | ___ | ___ | |
| 3. Has the person ever had a serious reaction to influenza vaccine in the past? | ___ | ___ | ___ | |
| 4. Has the person ever had Guillain-Barré syndrome? | ___ | ___ | ___ | |

I have been provided a copy of and have read or have had explained to me the information about influenza and the vaccine listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

If insured, I authorize Yankton Medical Clinic, P.C. to release medical information necessary to determine benefits payable for this service. I understand that I am financially responsible for services regardless of insurance coverage.

Signature _____

Person to be vaccinated
(If minor, parent or guardian)

Date _____

INFLUENZA VACCINE CONSENT FORM - PAGE 2

for office use only		Chart #:		Medical Records :				
INFLUENZA	Type	Date/Time	vaccine Manufacturer (Circle)	Vaccine Lot Number	Dose	IM Site (Circle)	Date of VIS Publication	Signature of person administering vaccine
	IIV4		Sanofi Pasteur ID Biomed GlaxoSmithKline		0.5 mL 0.25 mL	L R Deltoid T	8/6/21	
Abbreviation Key: IIV4 - Inactivated Influenza Vaccine, Quadrivalent IM - Intramuscular L - Left R - Right								

PRIVATE PAY / INSURANCE FLU SHOT	STATE SUPPLY FLU SHOT - ALL CHILDREN 6 MONTHS THRU 18YRS
90471.01 (Injection)	90471.S (Injection)
90686 (Pres. Free vaccine 6 months+) 0.5ml	90686.01 (State Pres. Free vaccine 6 months - 18 years)
90682 Flu Blok (18yrs + egg allergy and 50-64yrs hi-dose)	90672.01 (State Flu mist 2-49 years)
	90473.S (Injection)
MEDICARE FLU SHOT	PNEUMOVAX
G0008 (Injection)	G0009 Injection - Medicare
90662 (Hi-dose vaccine 65yrs+)	90471 Injection - Non-Medicare
FLUMIST	90472 Injection - Non-Medicare each additional
90672 Flumist intranasal (2-49yrs)	90732 Vaccine (PCV23)
90473.01 Intranasal administration	90670 Vaccine (PCV13)
	DIAGNOSIS FOR ALL VACCINES:Z23