TWO RIVERS PUBLIC HEALTH DEPARMENT INFLUENZA/COVID-19 CONSENT FORM

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	MAIDEN NAME (IF APPLICABLE)

DATE OF BIRTH	AGE	SEX	MOTHER'S MAIDEN NAME (FIRST AND LAST)	PHONE
_ _/ _ _/ _ _ _ _		☐ F ☐		

STREET ADDRESS	P.O.BOX (IF APPLICABLE)	CITY	STATE	ZIP

Race: **Ethnicity:** Hispanic/Latino Not Hispanic/Latino **Language** **Interpreter Needed :** Yes No

INSURANCE INFORMATION

RELATIONSHIP OF PATIENT TO INSURANCE SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SUBSCRIBER NAME (IF DIFFERENT THAN ABOVE)	SUBSCRIBER BIRTH DATE _ _/ _ _/ _ _ _ _	SOCIAL SECURITY #

MEMBER ID	GROUP #	

PHOTO OF CARD (FRONT & BACK) ☐ PHOTO COPY ATTACHED

INSURANCE PROVIDER

☐ BLUE CROSS BLUE SHIELD
☐ UNITED HEALTH CARE
☐ MEDICAID: **CIRCLE ONE**
UHC Com Plan NTC Molina
☐ MEDICARE (SS# REQUIRED)
☐ NO INSURANCE
☐ OTHER:_____

SCREENING QUESTIONNAIRE- Questions must be completed before vaccine is administered

DO YOU HAVE ALLERGIES TO EGGS OR A VACCINE COMPONENT?	☐	☐	UNKNOWN
HAVE YOU EVER HAD DIFFICULTY BREATHING AFTER RECEIVING A VACCINATION?	☐	☐	UNKNOWN
HAVE YOU HAD A SEIZURE, BRAIN/NERVOUS SYSTEM DISORDER OR GUILLAIN-BARRE?	☐	☐	UNKNOWN

I GIVE CONSENT to the **Two Rivers Public Health Department** and its staff to vaccinate the person listed on this form. I have read or had explained to me the Emergency Use Authorization or been provided a Vaccine Information Statement and understand the risks and benefits. I hereby grant permission to Two Rivers Public Health Department to release any pertinent information to the above insurance company upon request and any physicians to whom I might be referred. I agree and acknowledge that TRPHD or any of its volunteer's or partnering agencies, are not liable for the actions or omissions of, or the instructions given by the staff, volunteers, or partnering agencies who perform the vaccination. I will be notified by Two Rivers Public Health Department if vaccine was NOT able to be administered.

_____ / _____ / _____

Authorized Signature (*client, if 19 or older, or parent/legal guardian)* Today's Date: *(month/day/year)*

Office Use Only:

VACCINE MANUFACTUER	LOT/EXP	VFC/VFA/PVT	ADMIN CODE	SITE	NURSE/DATE
COMIRNATY mRNA 91320 (Gray) 12+			90480	LA RA	
PFIZER BioNTech 91319 (Blue) 5-11			90480	LA RA	
Flulaval (Reg 6m-64y) GSK 90686			1-90471	LA RA	
Flucelvax (Reg 6m-64y) Sequiris 90686			1-90471	LA RA	
Fluad (High Dose 65+) GSK 90694			1-90471	LA RA	
Home Visit			M0201		

Temp_____ O2_____ HR_____ BP _____

VIS Date:_____ VIS Published_____ Pt Rights & Responsibilities _____

NESIIS_____ Billed_____ Paid Cash/Donation _____