

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

PATIENT INFORMATION

LAST NAME			FIRST NAME		MI		MAIDEN NAME (IF APPLICABLE)	
DATE OF BIRTH --/--/----	AGE	SEX M F	MOTHER'S MAIDEN NAME (FIRST AND LAST)			PHONE		
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			INSURANCE PROVIDER ☐ BLUE CROSS BLUE SHIELD ☐ UNITED HEALTH CARE ☐ MEDICAID: CIRCLE ONE UHC Com Plan NTC Molina ☐ MEDICARE (SS# REQUIRED) ☐ NO INSURANCE ☐ OTHER: _____				
SUBSCRIBER NAME (IF DIFFERENT THAN ABOVE)		SUBSCRIBER BIRTH DATE --/--/----				SOCIAL SECURITY #	
MEMBER ID		GROUP #					
PHOTO OF CARD (FRONT & BACK) ☐ PHOTO COPY ATTACHED							

SCREENING QUESTIONNAIRE- Questions must be completed before vaccine is administered

DO YOU HAVE ALLERGIES TO EGGS OR A VACCINE COMPONENT?	YES	NO	UNKNOWN
HAVE YOU EVER HAD DIFFICULTY BREATHING AFTER RECEIVING A VACCINATION?	YES	NO	UNKNOWN
HAVE YOU HAD A SEIZURE, BRAIN/NERVOUS SYSTEM DISORDER OR GUILLAIN-BARRE?	YES	NO	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 _____

