Say SHOO to the FLU!
Parker County Hospital District Outreach Program

FLU Consent Form For Adults

Parker County Hospital District
OUTREACH PROGRAM
1115 Pecan Drive
Weatherford, TX 76086
(817) 458 - 3254

PATIENT INFORMATION

FIRST NAME: | MI | LAST NAME:

DATE OF BIRTH: (M M / D D / Y Y Y Y) | AGE: | GENDER: MALE FEMALE

ADDRESS:

CITY: | ZIP CODE:

CELL PHONE NUMBER: ___ - ___ - ____

REQUIRED INSURANCE INFORMATION (PLEASE CHECK THE BOX THAT APPLIES):

☐ NO INSURANCE ☐ MEDICARE

PRIVATE INSURANCE INFORMATION (PLEASE FILL IN **ALL** REQUESTED INFROMATION):

☐ AETNA ☐ BLUE CROSS ☐ CIGNA ☐ HUMANA ☐ UNITED

MEMBER ID (POLICY) NUMBER: | GROUP NUMBER:

POLICY HOLDER'S FIRST NAME: | POLICY HOLDER'S LAST NAME:

POLICY HOLDER'S DATE OF BIRTH: (M M / D D / Y Y Y Y)

☐ TRICARE *** SOCIAL SECURITY NUMBER IS REQUIRED BY INSURER FOR FILING ***

___ - ___ - ____

★ VACCINATION AND HEALTH QUESTIONS: ★

1.	Is the person to be vaccinated feeling sick today?	YES	NO
2.	Has the patient ever had a severe or life threatening allergic reaction to the flu vaccine?	YES	NO
3.	Does the patient have an allergy to eggs or any components of the flu vaccine?	YES	NO
4.	Has the patient ever been diagnosed with Guillain-Barre Syndrome?	YES	NO

Authorization for the Administration of the Influenza Vaccine

I am providing this consent form to Parker County Hospital District in order that I may be given the influenza vaccination. I have read and understand the information I have received concerning the possible benefits and side effects of the Influenza vaccination. I hereby acknowledge that, based on the information presented to me, I am eligible to receive the influenza vaccine on this date. I am feeling well today and I have not recently had fever. I understand that no assurance can be given that the influenza vaccination will give me immunity from contracting any strain of influenza. I hereby acknowledge that I have received access to the Vaccine Information Sheet regarding the Influenza Vaccine. I release Parker County Hospital District, its employees, representatives and agents from any liability for giving me the influenza vaccination. I accept responsibility for seeking medical attention for any problems associated with my receiving the vaccine. I have had the opportunity to have all my questions answered. I understand that this consent is valid for 6 months and I will make PCHD/employer/school aware of any changes prior to being vaccinated. If applicable, I authorize PCHD to provide my child's school with documentation of vaccinations given today.

Signature of Patient _____ **Date**

PCHD Staff Signature _____ **Date** _____

*** FOR ADMINISTRATIVE USE ONLY ***

Clinic Location: _____ Date: / /

Vaccine Lot: _____ Exp. Date: / /

Administered by: _____ Location: RA LA 0.5ml

For CDC information about the flu vaccine, scan this QR code with your phone: