

**Macomb County Health Department Seasonal Influenza Vaccine Program** Today's Date: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Child's Legal Name: \_\_\_\_\_  
(Last) (First) (Middle)

Parent/Responsible Party: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Sex (Circle One): Male Female  
(Area Code)

**Race:**  White  American Indian/Native Alaskan  Black/African American  Multiracial  
 Native Hawaiian/Pacific Islander  Asian **Ethnicity (Circle if applies):** Hispanic

**Are you enrolled in any of the following?** \_\_\_\_\_ Medicare Part B \_\_\_\_\_ Medicaid \_\_\_\_\_ No Medical Insurance  
\_\_\_\_\_ Commercial Insurance that **does** cover immunizations \_\_\_\_\_ Commercial Insurance that **does not** cover immunizations

**Medical Screening Questionnaire and Consent for Vaccination**

- | YES                      | NO                       | <i>Please answer the following questions about you or the person to be vaccinated:</i>  |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a serious reaction to a vaccine?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you allergic to eggs, Thimerosal, gelatin, or any antibiotics?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you receive an influenza vaccination during the 2010-2011 flu season?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had Guillain-Barré Syndrome (GBS)?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any long-term health problem such as heart or lung disease, kidney disease or metabolic disease (diabetes)?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have severe thrombocytopenia (low platelet count) or a bleeding disorder?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently ill or running a fever?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have asthma or have you had a recent episode of wheezing in the past 12 months?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently receiving aspirin therapy?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you or do you think you may be pregnant?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you received any vaccine within the past 30 days?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have cancer, leukemia, lymphoma, or any immune deficiency disease (inability to fight infection) <u>or</u> are you currently receiving chemotherapy, radiation therapy or steroid therapy (prednisone or cortisone)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have close contact with anyone who has a severely weakened immune system (for example, an individual who has had a bone marrow transplant and is currently in a hospital isolation room)?                            |

I have read or have had explained to me, the information contained in the Vaccine Information Statement(s) regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Macomb County Health Department to release my immunization record information, or the immunization record information of the person for whom I am authorized to make this request to other health care provider(s) as needed.

**Macomb County Health Department Notice of Health Information Practices**

I have received a copy of Macomb County Health Department's Notice of Health Information Practices. I understand that my acknowledgement of the Notice is evidenced by my signature on this document. The Department is required to abide by the terms of this privacy notice. The Department may change the terms of its notice at any time. The new notice will be effective for all protected health information that it maintains at that time. Upon my request, the Department will provide me with the revised notice of privacy practices.

**X** \_\_\_\_\_  
SIGNATURE of Parent/Legal Guardian PRINT NAME of Parent/Legal Guardian (if applicable)

**Received Notice of Health Information Practices**  
**REFUSED written acknowledgement**

**THIS SIDE OF FORM TO BE COMPLETED BY MACOMB COUNTY HEALTH DEPT STAFF ONLY**

**MCHD OFFICE STAFF USE ONLY**

Today's Date: \_\_\_\_\_

\_\_\_\_ Medicare    \_\_\_\_ Self Pay    MC (01) \_\_\_\_\_    Client ID \_\_\_\_\_  
\_\_\_\_ Medicaid    \_\_\_\_ No Pay (Waived/250)    WRN (02) \_\_\_\_\_    SCS (03) \_\_\_\_\_    (91/92/93) Facility Zip Code \_\_\_\_\_  
Does client have HAP Insurance? **YES** **NO**    (MCHD cannot accept HAP MEDICARE/becomes self pay client)

Nurse Staff ID \_\_\_\_\_

Nurse Confirmation of Client's Birthdate: \_\_\_\_\_

**Vaccine**                      **Mfg/Lot#**                                      **Route**                      **Site**                      **VIS Date**                      **VIS Given**

FLUT/FLTC/FLUV/FLU \_\_\_\_\_                      IM                      RT    LT    RD    LD                      07/26/2011                     

(circle one)

LAIV/FLUM \_\_\_\_\_                      Nasal (IN)                      Nasal                      07/26/2011                     

Next Date Due for Immunizations: \_\_\_\_\_

Progress Notes: \_\_\_\_\_

**Please copy Medicare Part B card or MEDICAID card/commercial insurance cards.**

(If Medicare Part A only, do not copy Medicare card; client becomes self pay client)