Fargo Cass Public Health

1240 25 St S
Fargo ND 58103 (701).241.1360

INFLUENZA CONSENT

PRINT Patient's Last Name	First Name	M.I.	Date of Birth	Age	☐ Male ☐ Female

Address	City	State	Zip	Phone

I have read or have had explained to me the information about influenza and influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and request that the vaccine be given to me or to the person named above for whom I am authorized to make this request. By signing this document, I authorize the release of medical information necessary to process any insurance claim and payment of benefits to Fargo Cass Public Health. I understand that I am legally obligated to pay for medical services not covered by a third-party payer.

X _____ _____
Signature of Patient or Responsible Person Date

Is your employer responsible for your flu immunization bill?

☐ **No** ☐ **Yes, provide name of employer:**_____

Complete primary insurance section below and secondary insurance section if applicable.

Primary Policy Holder Information

Last Name_____ **First Name**_____ **Middle Initial**____

Date of Birth _____ ☐ **Male** ☐ **Female**

Insurance Company Name_____

Policy Number_____ **Group Number (if applicable)**_____

Secondary Policy Holder Information (if applicable)

Last Name_____ **First Name**_____ **Middle Initial**____

Date of Birth _____ ☐ **Male** ☐ **Female**

Insurance Company Name_____

Policy Number_____ **Group Number (if applicable)**_____

******FOR OFFICE USE ONLY****** **VIS: 08/15/2019**

Egg Or Latex Allergy	Acute Illness or Fever	Prior Reaction to Flu Shot	Guillain Barre	Admin Site	FLULAVAL CPT:90686,20 Man: GSK Exp:	FLUBLOK CPT:90682,2 Man: SP Exp:	FLUARIX CPT: 90686,200 Man: GSK Exp:	FLUZONE CPT: 90686,2 Man: SP Exp:	FLUZONE HIGH-DOSE CPT: 90662,2 Man: SP Exp:	Date Given
				LA RA	Lot#	Lot#	Lot#	Lot#	Lot#	

_____
Signature of Administrator RN

Location: Mass Clinic (60)

FARGO CASS PUBLIC HEALTH
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received and/or reviewed a copy of the Fargo Cass Public Health Notice of Privacy Practices. If I am not the client, I represent that I am legally authorized to sign this document on the client's behalf.

Today's Date	
Client's Date of Birth	
Client's Name (print)	Authorized Agent's Name (print)
Client's Signature	Authorized Agent's Signature
FARGO CASS PUBLIC HEALTH USE: To be completed if unable to obtain a signed acknowledgement after a good faith effort was made to do so.	
Reason not obtained:	
Employee Signature	Date
	LABEL