11/29/2022

Consent for Influenza for **Individuals 19 Years and Older**

DHD 100 Mack Ave. Detroit, MI 48201

Client Name: _____ Birthdate: _____/_____/_____Sex: M F

Street Address: _____ City: _____ State: _____ Zip: _____

Phone Number (preferred):_____ cell home other

	Yes	No
1. Are you sick today?		
2. Do you have allergies to medications, food, a vaccine component, or latex?		
3. Have you ever had a serious reaction after receiving a vaccination or immune globulin?		
4. Have you received any vaccines in the past 4 weeks?		
5. Have you ever had a reaction related to anti-IgA antibodies, or a history of IgA deficiency?		
6. Do you have long term health problems with heart disease, lung disease (including asthma), immune system, neurologic disease, metabolic disease (diabetes), kidney disease, liver disease?		
7. Do you have anemia, a blood disorder, bleeding disorder or take anticoagulant medication (blood thinner)?		
8. Have you ever had Guillain-Barre Syndrome (temporary severe muscle weakness) within 6 weeks of receiving flu vaccine?		
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?		
Flu Mist:		
1. Are you older than age 49 years? (flu mist is for age 2 through 49 years)		
2. Do you have cancer, leukemia, HIV/AIDS, any immune system problems; or, in the past 3 months have you taken medications that affect the immune system, such as prednisone, other steroids, drugs for treatment of rheumatoid arthritis, Crohn's disease, psoriasis or anticancer drugs; or have you had radiation treatments?		
3. Are you taking any influenza antiviral medications?		
4. Do you live with someone or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation?		

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered and VIS Given	Route	Site (Circle One)	Dose	Vaccine Manufacturer	Lot Number	Date of VIS
Influenza		IM	LA RA	0.5 mL			08/06/2021
Influenza HD		IM	LA RA	0.5 mL			8/06/2021
Influenza		Nasal		0.2 mL			

Eligibility Status: Private VRP

Signature and Title of Vaccine Administrator: _____ Date: _____

Notes:

DETROIT HEALTH DEPARTMENT
General Clinic Consent

HIPAA Acknowledgement

I _____ (print name) giver permission for the Detroit Health Department to give me or the minor child I have authority to consent on behalf of medical related services or treatment. I have the right to refuse any procedure or treatment.

Consent for Vaccination

I have read, or have had explained to me, the Vaccine Information Statement for the vaccine (available online at www.michigan.gov/mdhhs). Questions about vaccines have been answered to my satisfaction. I understand the benefits and risks of the vaccine (s) requested and ask that the vaccine (s) be given to me or to the person named above for whom I am authorized to make this request. I understand that a record of this immunization may be shared through MCIR (Michigan Care Improvement Registry) and with other health care providers directly involved with the vaccinated person's care. This consent form authorizes the administration of multiple doses of a vaccine, if medically indicated. Combination vaccines will be used as available, unless contraindicated. This consent form will expire after the last vaccination is given in a vaccine series. **I understand that if I chose to decline recommended vaccine a refusal form must be completed and signed.**

_____ _____

Patient Guardian Signature Date

I allow the Detroit Health Department to file for insurance benefits to pay for the care I receive. I understand that the Detroit Health Department will have to send my medical record information to my insurance company. I must pay my share of the costs of these services if my insurance does not pay, or I do not have insurance.

_____ _____

Patient or Guardian Signature Date

Notice of Privacy Practices Acknowledgement

I received the Detroit Health Department's Notice of Privacy Practices. The Notice of Privacy Practices tells me the ways in which the health department may use and share my healthcare information for its treatment, payment, healthcare operations and other allowed uses.

_____ _____

Patient or Guardian Signature Date