HARRISON COUNTY
Home & Public Health
Department

Child and VFC Flu Consent Form

Courthouse Annex
116 N. Second Ave.
Logan, IA 51546
Ph: (712) 644-2220

Amount Paid: _____

Cash or Check #: _____

Make checks payable to HCHPH

PLEASE PRINT

Child's Legal Name: _____ Birth Date: ____/____/____
Last *First* *Middle Initial* *Month* *Date* *Year*

Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Male _____ Female _____ Physician's Name: _____

Has the child ever had a serious reaction to eggs or any component of the influenza vaccine? Yes____ No ____
Is the child sick today? Yes_____ No _____
Has the child ever had Guillain Barré syndrome? Yes_____ No _____

PAYMENT

The cost will be $25 if:

☐ My child has private insurance.
☐ My child is enrolled in hawk-i
(If enrolled in Hawk-i, the flu vaccine may be obtained through your physician as a covered service.)

To qualify for vaccination at **NO COST** through the Vaccines For Children (VFC) program one of the following must apply (check one):

☐ My child is enrolled in Medicaid. Medicaid ID #: _____
☐ My child **DOES NOT** have insurance.
☐ My child is American Indian or Alaska Native.
☐ My child has health insurance that **DOES NOT** pay for vaccines.
Insurance Provider:_____ID #: _____

I have read the vaccine information statement, or have had the information explained to me. I have had a chance to ask questions and I understand the benefits and risks of the vaccine and ask that the vaccine be given to my child. I accept responsibility for seeking medical attention for any reactions to the vaccination.
CDC-VIS 08/07/2015 _____(Initial)

I certify that I have been offered a copy of the Harrison County Home & Public Health Privacy Notice.

Signature: _____ **Date:** ____/____/____
Month *Date* *Year*

Please Print Name:_____ **Parent:** _____ **Guardian:** _____

NURSES ONLY

Flu vaccine - Site: RD/LD Lot #_____

Administered by: _____ Entered Into IRIS: _____