

**Nevada Division of Public and Behavioral Health  
Rural and Community Health Services  
2020-21 Seasonal Influenza Consent Form**

Insight # _____ WebIZ # _____
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Please **PRINT** the following information:

*Last Name* \_\_\_\_\_ *First Name* \_\_\_\_\_ *Birth Date* \_\_\_\_\_

*Address* \_\_\_\_\_ *City state and ZIP* \_\_\_\_\_

*Telephone Number* \_\_\_\_\_

*Sex* Male Female *Marital Status* \_\_\_\_\_ *How old are you today* \_\_\_\_\_ *Are you Hispanic* Yes No

*Is your race* White / Black-African American / American Indian-Alaskan Native / Asian / Native Hawaiian-Pacific Islander

**Please answer the following questions. Check one box per question.**

- |   | Yes                              | No   |
|---|----------------------------------|--|
| 1. Is the person to be vaccinated sick today?   | <input type="checkbox"/>         | <input type="checkbox"/>   |
| 2. Does the person to be vaccinated have an allergy to a component of the vaccine?                  | <input type="checkbox"/>         | <input type="checkbox"/>   |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?    | <input type="checkbox"/>         | <input type="checkbox"/>   |
| 4. Has the person to be vaccinated ever had Guillain-Barré syndrome?                                | <input type="checkbox"/>         | <input type="checkbox"/>   |
| 5. May we immunize you/your child today?  | <input type="checkbox"/>         | <input type="checkbox"/>   |
| 6. Please indicate your insurance status *you will not be billed – for informational purposes only* | <input type="checkbox"/> Insured | <input type="checkbox"/> Uninsured <input type="checkbox"/> Medicaid |

**Consent and Release Statement**

I have received and understand the Vaccine Information Statement for Influenza to be administered to me or to the person named above, for whom I am authorized to make this request. I also agree to allow my immunization information or the person named above, for whom I am authorized to make this request to be stored and accessed by users in Nevada's "WebIZ" computer system unless I indicate otherwise.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**For Office Use Only**

**Influenza Quad Inj** (*FluLaval Quad PF 2020-2021 0.5mL sd syr*) (6 months + ):

317 LOT# 494S5 Exp. 6/30/2021

SITE: IM Deltoid:  Left  Right  
IM Thigh:  Left  Right

<b>White Pine County Community Health</b> 297 Nevada Northern Rail Way, Suite 5 Ely, NV 89301
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- |   |
|---|
| <input type="checkbox"/> Homebound<br><input type="checkbox"/> Clinic _____<br><input checked="" type="checkbox"/> <b>POD</b> _____<br><input type="checkbox"/> Other _____ |
|---|

**Entered into WebIZ**

Nurse/EMS/Pharmacist Signature \_\_\_\_\_