

STUDENT INFLUENZA REGISTRATION FORM

Required information inside the **boxed in areas** must be filled in



STUDENT'S BASIC INFORMATION

Name of Student: _____ Sex: Male Female
Last First Middle Initial

Name of Legal Guardian: _____ Student's Date of Birth: ____/____/____
Last First Month Day Year

Student's Age: _____ Street Address: _____

Apt. #: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Does the student consider himself/herself Hispanic or Latino? Yes No

Which category best describes the race of the student? (please select all that apply)

- White Black or African American Asian Native Hawaiian or Pacific Islander American Indian or Alaska Native Other

BILLING INFORMATION

Insurance Information: CareSource Molina Medicaid Other: _____

Information from insurance card: Subscriber ID or member #: _____ Group #: _____

Phone # on insurance card: _____

Claims address on insurance card: _____

The student does not have health insurance (sign here for hardship waiver)

I am unable to pay for services rendered: _____

SCREENING INFORMATION

1. Does the student have an allergy to eggs, or to any other component of the influenza vaccine (including polymyxin, neomycin, gentamicin, and gelatin)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the student ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has the student ever had Guillain-Barré syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Does the student have ongoing health problems (like diabetes, autoimmune, neurologic, heart or lung problems, asthma) or take aspirin regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. If the student is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does the student have a weak immune system or close contact with someone whose immune system is severely weak?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Is the student pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has the student received other live-virus vaccines (MMR, chickenpox) in the past 4 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Did the student receive the seasonal influenza vaccine last year? (If unsure mark No)	<input type="checkbox"/> Yes <input type="checkbox"/> No

CONSENT BY GUARDIAN

I have read and understand the information about influenza and influenza vaccine. I have had a chance to ask questions. I understand the benefits and risks of influenza vaccination and ask that the vaccine be given to me or the person named above for whom I am authorized to sign. I give consent for my child named at the top of this form to get vaccinated for one or two doses, as needed. I also understand that any care received outside Columbus Public Health (e.g., referred care) will not be paid for by Columbus Public Health. I authorize the release of medical information necessary to process this claim for billing. I understand I may be billed for my co-pay and for any charges not covered by insurance or grants, unless I sign the hardship waiver above.

I understand that the Privacy Notice of Columbus Public Health is available on the internet at: publichealth.columbus.gov/Asset/iu_files/HIPAA_Privacy_Notice.pdf. I can also have it mailed to me by calling 614-645-2738.

Parent/Legal Guardian Signature: _____ Date: ____/____/____

DO NOT WRITE BELOW THIS LINE - Health Department Use Only

Student is not ill on day of vaccination

Staff Screener Signature: _____

Manufacturer: _____

Lot Number: _____ Expiration Date: ____/____/____

Office Assessment(99211/15) NG encounter# _____ TC _____ TP _____

Flumist (90660/10) Nasal

Injectable 0.5ml (90658/10) Left Deltoid IM Right Deltoid IM

Nurse Signature: _____ Date: ____/____/____