2024-25 ADULT FLU CONSENT

Parker County Hospital District
Outreach
1115 Pecan Drive Weatherford, TX 76086
(817) 458-3254 www.pchdtx.gov

PATIENT INFORMATION

FULL NAME:

Date of Birth: / / Age: Gender: Male Female

ADDRESS:

CITY: ZIP CODE:

CELL PHONE NUMBER:

REQUIRED INSURANCE INFORMATION (PLEASE CHECK THE BOX THAT APPLIES):

By completing the following insurance section, I authorize payment of medical benefits for any services provided. This information will be used for the purpose of evaluating and administering claims of benefits.

☐ AETNA ☐ BLUE CROSS ☐ CIGNA ☐ HUMANA ☐ UNITED

Subscriber (Policy Holder) Name:

Subscriber (Policy Holder) DOB: / /

MEMBER ID (POLICY) NUMBER:

GROUP NUMBER:

☐ TRICARE (MILITARY INSURANCE):

Subscriber (Policy Holder) Name:

Subscriber (Policy Holder) DOB: / /

Subscriber SS# NUMBER:

Subscriber DOD NUMBER:

★ VACCINATION AND HEALTH QUESTIONS: ★

☐	1. Is the person to be vaccinated feeling sick today?	YES	NO
☐	2. Has the patient ever had a severe or life threatening allergic reaction to the flu vaccine?	YES	NO
☐	3. Does the patient have an allergy to any components of the flu vaccine?	YES	NO
☐	4. Has the patient ever been diagnosed with Guillain-Barre Syndrome?	YES	NO
☐	5. Has the patient ever felt dizzy or faint before, during or after a shot?	YES	NO

Authorization for the Administration of the Influenza Vaccine

I am providing this consent form to Parker County Hospital District in order that I may be given the influenza vaccination. I have read and understand the information I have received concerning the possible benefits and side effects of the influenza vaccination. I hereby acknowledge that based on the information presented to me, I am eligible to receive the influenza vaccination on this date. I am feeling well today and I have not recently had a fever. I understand that no assurance can be given that the influenza vaccination will give me immunity from contracting ANY strain of influenza. I hereby acknowledge that I have received access to a copy of the Vaccine Information Sheet, via the provided QR code, on the 2024-2025 Influenza Vaccine. I release Parker County Hospital District, its employees representatives and agents from any liability for giving me the influenza vaccination. I accept responsibility for seeking medical attention for any problems associated with my receiving the vaccine. I have had the opportunity to have all my questions answered. I understand that this consent is valid for 6 months and I will make PCHD aware of any changes prior to being vaccinated.

Signature of Patiant Date

For detailed information about the flu vaccine, scan this QR code with your phone

PCHD Staff Signature Date

Clinic Location: _____

Date: __/_____/_____

Vaccine Lot #: _____

Expiration Date: _____

Location: LA RA

Administered by: _____