



302 California Ave Suite # 106 Wahiawa, Hi 96786

Name: Last:		First:		Middle Initial:	
Date of Birth: Month:		Day:		Year:	
Address:				Mobile Phone #:	
City:				Apt/Room #:	
State:		Zip:			
SEX (gender assigned at birth) <input type="checkbox"/> Female <input type="checkbox"/> Male		Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian or Other <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other <input type="checkbox"/> Pacific Islander or Other <input type="checkbox"/> White <input type="checkbox"/> Other Non White		Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino <input type="checkbox"/> Unknown	
Primary Insurance Carrier ID#:		GRP#:			
Insurance Company:		Insurance Company Phone Number#:			
Insured's Name:		Relationship:		Insured's DOB	
Secondary Insurance Carrier ID#:		Grp#:			
Insurance Company:		Insurance Company Phone #:			
Insured's Name:		Relationship:		Insured's DOB:	

Screening for Vaccine Eligibility

Was your child vaccinated with the seasonal influenza vaccine after July 1, 2022? YES NO

The following questions will help us to know if your child can get the seasonal influenza vaccine. If you answer "NO" to all four of the following questions, your child can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, your child may be able to get the seasonal influenza vaccine, but we will contact you to discuss your options.

Please mark YES or NO for each question.

	YES	NO
1. Does your child have a serious allergy to eggs?		
2. Does your child have any other serious allergies? Please list:		
3. Has your child ever had a serious reaction to a previous dose of flu vaccine?		
4. Has your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?		

I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient and confirm that the patient is at least 18 years of age; or (c) authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Wahiawa Community Health Center, as an agent of the Hawaii Department of Health to administer the Influenza Vaccine.

I understand that it is not possible to predict all possible side effects or complications associated with receiving this vaccine (s). I understand the risks and benefits associated with the above vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.

I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation. If I experience a severe reaction, I will call 911 or go to the nearest hospital. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless Wahiawa Health, their employees, officers, directors, and contractors from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.

I acknowledge that I have been advised that Wahiawa Health makes no firm guarantees regarding administration of subsequent vaccines. Vaccine supply is dependent on Federal allotment to the state of Hawaii and is not in control of the health center.

I acknowledge that: (a) I understand the purpose/ benefits of Vaccine Administration Management System immunization registries and (b) Wahiawa Health will include my personal information and personal immunization information to be shared with the State of Hawaii Department of Health (DOH) and with the Centers for Disease Control (CDC, and/) or other federal agencies.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION and ASSIGNMENT OF INSURANCE BENEFITS

I authorize Wahiawa Center for Community Health (Wahiawa Health) to release to my insurance company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I hereby authorize that payments for these services be made directly to my physician or supplier.

Signature

Relationship to Patient

Date

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges whether paid by said insurance. These include deductible, co-payment, cost-share, and/or non-covered benefits. I also agree to pay a late payment fee of 1% a month on any unpaid balance over 90 days old together with reasonable attorney's fees and collection expenses should the account be referred to an attorney or collection agency. I agree to pay \$10.00 processing fee for each returned check.

I certify that the insurance information I have provided is correct. I permit a copy of this authorization to be used in place of the original. This authorization is valid until revoked by me in writing.

Patient/Parent/Guardian Signature

Relationship to Patient

Date

I GIVE CONSENT to the Wahiawa Center for Community Health and its staff for my child named at the top of this form to be vaccinated with this vaccine. (If this consent form is not signed, then you child will not be vaccinated)

I DO NOT GIVE CONSENT to the Wahiawa Center for Community Health and its staff for my child named at the top of this form to NOT be vaccinated with this vaccine.

Signature of Patient/Authorized Representative: _____ **Date:** _____

Print name of Representative and Relationship: _____

I HAVE BEEN ADVISED TO WAIT FOR 15-30 MINUTES OF OBSERVATION AFTER RECEIVING MY VACCINE BEFORE LEAVING.

Signature: _____ **Date:** _____

Form reviewed by: _____ **Date:** _____

FOR ADMINISTRATIVE USE ONLY

Date Administered ____/____/____ Time Administered _____ Time Discharged _____

Vaccine Manufacturer _____ Lot # _____ EXP Date _____

Site: Left Deltoid Right Deltoid Signature and Title of Person Administering Vaccine

Observed: 15 MIN 30 MIN Adverse Reaction? Yes No