302 California Ave Suite # 106 Wahiawa, Hi 96786

Name: Last:	First:	Middle Initial:
Date of Birth: Month: Day: Year:	**Mobile Phone #:**	
Address:		**Apt/Room #:**
City:	**State:**	**Zip:**
SEX (gender assigned at birth) ☐ Female ☐ Male	**Race** ☐ American Indian or Alaska Native ☐ Asian or Other ☐ Black or African American ☐ Native Hawaiian or Other ☐ Pacific Islander or Other ☐ White ☐ Other Non White	**Ethnicity** ☐ Hispanic or Latino ☐ Non Hispanic or Latino ☐ 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:___________

<u>Screening for Vaccine Eligibility</u>

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

☐ **YES! Vaccinate my Keiki. 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 your child will not be vaccinated)

☐ **NO! DO NOT VACCINATE MY KEIKI. 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 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.

FOR ADMINISTRATIVE USE ONLY

Signature: ____ Date:___________________________

Form reviewed by: ______________________________________ Date: ___________________________

Date Administered ____/____/____ Time Administered __________ Time Discharged __________
Vaccine Manufacturer _______________ Lot # _______________ EXP Date _______________
Site:☐Left Deltoid ☐Right Deltoid Signature and Title of Person Administering Vaccine

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Observed:☐ 15 MIN ☐30 MIN Adverse Reaction? ☐Yes ☐No