HEALTH SERVICES

# Flu Vaccine Consent Form – 2020/2021

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|---|---|---|
| Date of Birth (Month/Date/Year): | Age: | Sex: ___M ___F |
| Last Name: | First Name: | |
| Address: | | |
| City/State/ZIP: | | |
| Cell Phone: | Home Phone: | |
| SNC Status: ____ Student ____ MCW Student ____ Employee ____ Spouse/SNC Employee Name: _____ | | |
| Insurance Status:<br>_____ **Verified current insurance information is on file with Health Services / Entered into Medicat Patient Portal**<br>_____ **No Insurance / Self-Pay - Please process fee to my Bursar account** | | |

**MEDICAL HISTORY:**

**___No ___Yes** 1) Have you ever received a flu vaccination in the past?
**___No ___Yes** 2) Have you ever had a severe reaction to a flu vaccination before?
**___No ___Yes** 3) Have you ever had Guillain-Barre Syndrome within 6 weeks of a previous flu vaccination?
**___No ___Yes** 4) Do you have an allergy to eggs?
**___No ___Yes** 5) Do you have a moderate to severe fever? (Temperature of 100.4°F or greater)
**___No ___Yes** 6) Are you under the age of 18?

I give my consent, voluntarily and of my own free will to the staff of St. Norbert College (SNC) Health Services Department to give me named above the Influenza Vaccine. I have been given a copy of the Vaccine Information Statement (VIS). The VIS publication date is 08/15/2019. A copy of the SNC Health Services Notice of Privacy Practices has been made available to me and I have been given the opportunity to ask questions. Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule.

**Recipient Signature: X** _____**Date**_____

| Lot # | Vaccine / Expiration Date | Site of Vaccine | Administered by |
|---|---|---|---|
| _____ **276553** | **Flucelvax- McKesson / Exp. 6/30/21** | Deltoid _____right _____left | |
| _____ **275KY** | **Flulaval – GSK / Exp. 6/30/21** | | |

HEALTH SERVICES

# Acknowledgement of Receipt of Privacy Notice
# Health Insurance Portability and Accountability Act of 1996

By signing this form, I acknowledge that St. Norbert College Health Services have made available to me its Privacy Notice, which explains how my health information will be handled in various situations. I may also go to the webpage to download a written copy of the HIPAA Policy at:
https://www.snc.edu/health/docs/hipaa/notice_of_privacy_practices2019.pdf
I have also been given a chance to discuss my concerns and questions about the privacy of my health information.

## Privacy Policy Agreement Signature

**HIPAA Privacy Policy:**
By your signature, you acknowledge that your HIPAA privacy rights are available for you review in this office. You also acknowledge that upon your request (verbally or in writing), a copy/summary of your protected health information (PHI) can be disclosed to you personally in a secure electronic format or in hard-copy. Any disclosure of your PHI to outside entities (not exempted from HIPAA), must be requested/authorized in writing.

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## Financial Responsibility Understanding

- ☐ I understand that Health Services is not an in-network provider for most insurance companies, but will attempt to bill the insurance company on file.
- ☐ I accept full responsibility for payment of balance due after services have been rendered.
- ☐ For employee/spouse, balances due will be posted on your account in the Bursar office.
- ☐ I have read, understand, and agree to the terms and conditions of this Health Services Financial Responsibility Agreement

_____ _____
First and Last Name (please print) Date of Birth (Mo/Day/Year)

_____ _____
Signature Today's Date