CLINIC SITE: ______________________________________ CLERK INITIALS: ________

PATIENT INFORMATION AND VACCINATION CONSENT

LAST NAME: _______________________________FIRST NAME: ________________________ MI _______

BIRTHDATE: _____/_____/_____ AGE: __________ FEMALE MALE

ADDRESS: _________________________________ CITY: ___________________ STATE: ___ ZIP: _______

PHONE: (_____) _________________________ COUNTY: ______________

1. Are you allergic to eggs or Thimerosal (mercury - containing preservative used in vaccines)?............................**YES NO**
2. Have you ever had an allergic reaction or other problem after a vaccination?...**YES NO** (Shortness of breath, hives, difficulty breathing, etc.)
3. Were you ever paralyzed by Guillain-Barre Syndrome?...**YES NO**
4. Do you feel well today?..**YES NO**

Only complete questions 5-9 IF you are between 2-49 years AND want the FLUMIST

5. Do you have a long-term health problem such as heart disease, lung disease (e.g. asthma), kidney disease, metabolic disease (e.g. diabetes), or blood disorder (e.g. anemia)?.. **YES NO**
6. Do you have a weakened immune system because of HIV/AIDS or other disorder, long –term treatment with drugs such as steroids, or cancer treatment with x-rays or drugs?.. .**YES NO**
7. Do you live with or have close contact with anyone with a severely weakened immune system requiring care in a protective environment?..**YES NO**
8. Do you take aspirin or other salicylate medication?.. **YES NO**
9. Have you received a MMR (measles/mumps/rubella) &/or varicella(chicken pox) vaccine in the past 4 weeks?... **YES NO**
10. Are you pregnant or could become pregnant within the next month?.. **YES NO**

....

How did you hear about this clinic? Newspaper Website Commercial Flu hotline TV/Radio News Other _____________

Do you have health insurance? **YES (IF YES- Please REFER TO BACK SIDE OF FORM) NO**

A donation of $15 is suggested, if you are unable to donate that amount, any donation you can make is appreciated.
If you choose to donate, please indicate the amount donated here $__________.

Checks are accepted and should be made payable to PCHD. Thank you.

PLEASE NOTE: CONSENT IS REQUIRED FOR EVERY PATIENT

I acknowledge receipt of the "Notice of Health Information Privacy Practices" for Polk County Health Department and understand all information is confidential and can only be released with my consent. INITIALS:____________

I have received and read the information sheet for the flu vaccination and have had the opportunity to ask questions. I understand the benefits and risks of the flu vaccination. I authorize the healthcare providers of the Polk County Health Department to administer vaccination to the patient named above. If applicable, I request that payment of authorized Medicare, Medicaid, Humana or Wellmark benefits be made directly to the Polk County Health Department.

SIGNATURE (or Legal Representative if patient under 18 years): _______________________________________DATE: _____

** STAFF ONLY **

The Polk County Health Department can ONLY bill the following insurances:

MEDICARE PART B, MEDICAID, HUMANA, WELLMARK, and RAILROAD MEDICARE

If patient has one of these insurances, please complete the appropriate information below:

Medicare Part B: MEMBER NAME____

ID #____

Medicaid: MEMBER NAME____

ID #____

Humana: MEMBER NAME ____

ID # ___________________________________

GROUP # _____________________________________

ADDRESS: ____

Wellmark: MEMBER NAME ____

ID # ____

NAME OF PLAN--- PLEASE CIRCLE

Alliance Select	Blue Access	Blue Advantage	Blue Choice
Classic Blue	Select First	Medicare Blue	Hawk-I

Railroad Medicare: MEMBER NAME ____

ID # _______________________________

VFC (if child): YES NO

VACCINATION ADMINISTERED

Nurse Signature:____Date:____________________

FLU **CPT: 90658 & 90471**

Vaccine:_____________________ **Exp. date:** _________

Lot #_______________________ **Mfr:**_______________

NDC #______________________

Site of Injection **Right Deltoid** **Left Deltoid**

FLU MIST: **CPT: 90660 & 90473**

Vaccine:_____________________ **Exp. date:** _________

Lot #______________________ **Mfr:**________________

NDC #______________________

PNEUMONIA: **CPT: 90732 & 90471**

Vaccine:_____________________ **Exp. date:** ________

Lot #______________________ **Mfr:**_____________

NDC #______________________

Site of Injection **Right Deltoid** **Left Deltoid**

Diagnosis:

Flu or Mist Only: V04.81

Pneumonia Only: V03.82

Flu and Pneumonia: V06.6