



CLINIC SITE: \_\_\_\_\_ CLERK INITIALS: \_\_\_\_\_

**PATIENT INFORMATION AND VACCINATION CONSENT**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI \_\_\_\_\_

BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ FEMALE  MALE

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ COUNTY: \_\_\_\_\_

How many doses of H1N1 did this patient receive last season? \_\_\_\_\_ seasonal flu last season? \_\_\_\_\_

- 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. Have you ever had 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 \_\_\_\_\_ GROUP # \_\_\_\_\_  
ID # \_\_\_\_\_ ADDRESS: \_\_\_\_\_

**Wellmark:** MEMBER NAME \_\_\_\_\_  
ID # \_\_\_\_\_

**PLAN NAME--PLEASE CIRCLE Alliance Select Blue Access Blue Advantage Blue Choice Classic Blue Select First Medicare Blue Hawk-I**

**Railroad Medicare:** MEMBER NAME \_\_\_\_\_  
ID # \_\_\_\_\_

**United Healthcare:** MEMBER NAME \_\_\_\_\_  
ID# \_\_\_\_\_ GROUP # \_\_\_\_\_

**Midlands Choice:** MEMBERS NAME \_\_\_\_\_  
ID# \_\_\_\_\_ GROUP # \_\_\_\_\_

**VFC (if child):**  YES  NO **If Yes:**  No Insurance  Underinsured  Medicaid Enrolled  Native American/Alaskan Native

Staff Signature \_\_\_\_\_ Date/VIS Given \_\_\_\_\_

**FLU** CPT: 90658 & 90471  
Exp. date: \_\_\_\_\_  
Lot # \_\_\_\_\_  
Mfr: \_\_\_\_\_  
NDC # \_\_\_\_\_ VIS Date: \_\_\_\_\_  
Site of Injection  R Delt  L Delt  R Thigh  L Thigh  
 0.25cc IM  0.50cc IM  
**FLU MIST:** CPT: 90660 & 90473  
Exp. date: \_\_\_\_\_  
Lot # \_\_\_\_\_ Mfr: MedImmune  
NDC # \_\_\_\_\_ VIS Date: \_\_\_\_\_

**PNEUMONIA:** CPT: 90732 & 90471  
Exp. date: \_\_\_\_\_  
Lot # \_\_\_\_\_ Mfr: \_\_\_\_\_  
NDC # \_\_\_\_\_ VIS Date: \_\_\_\_\_  
Site of Injection  R Deltoid  L Deltoid  R Thigh  L Thigh  
 0.50cc IM  
**Diagnosis:**  
Flu or Mist Only: V04.81  
Pneumonia Only: V03.82  
Flu and Pneumonia: V06.6

**Adolescent Immunizations**  
**Tdap** Lot # \_\_\_\_\_ VIS Date 11/18/08  
0.50cc IM  Sanofi Pasteur  GSK  
 LD  RD  
**HPV** Lot # \_\_\_\_\_ VIS Date 3/30/10  
0.50cc IM Merck  
 LD  RD  
**MCV4** Lot # \_\_\_\_\_ VIS Date 1/28/08  
0.50cc IM Sanofi Pasteur  
 LD  RD

1. Is the child/teen sick today?  Yes  No  
2. Does the child/teen have allergies to medications, food, or any vaccines?  Yes  No  
3. Has the child/teen had a serious reaction to a vaccine in the past ?  Yes  No  
4. Has the child/teen had a seizure, brain problem, or other nervous system problems?  Yes  No  
5. Is the child/teen pregnant?  Yes  No  
6. Has the child/teen had any vaccines in the past 4 weeks?  Yes  No  
Staff Signature \_\_\_\_\_ Date /VIS Given \_\_\_\_\_