



CLINIC SITE: \_\_\_\_\_

CLERK INITIALS: \_\_\_\_\_

**PATIENT INFORMATION AND VACCINATION CONSENT**

LAST NAME:		FIRST NAME:		MIDDLE INITIAL:
BIRTHDATE: / /	AGE:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
ADDRESS:		CITY:	STATE:	ZIP:
PHONE: ( )		COUNTY:		

WOULD YOU LIKE A FLU VACCINATION TODAY: YES/NO • WOULD YOU LIKE A PNEUMONIA VACCINATION TODAY: YES/NO

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Are you allergic to eggs or Thimerosal (mercury – containing preservative used in vaccines)?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 2. Have you ever had an allergic reaction or other problem after a vaccination? (Shortness of breath, hives, difficulty breathing, etc.) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 3. Have you ever had Guillian-Barre Syndrome?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 4. Do you feel well today?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Only complete **IF** you are between the ages of 2 and 49 years **AND** want FLUMIST, please complete questions 5-10.

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 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 a blood disorder (e.g. anemia)? | <input type="checkbox"/> YES | <input type="checkbox"/> 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?          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 7. Do you live with or have close contact with anyone with a severely weakened immune system requiring care in a protective environment?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 8. Do you take aspirin or other salicylate medication?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 9. Have you received an MMR (measles/mumps/rubella) and/or Varicella (chicken pox) vaccine in the past 4 weeks?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| 10. Are you pregnant or could become pregnant within the next month?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Are you currently covered by a health insurance policy listed below:  YES  NO

We accept Medicare Part B, Medicaid, Humana, Wellmark, Select One, United Healthcare, Midland's Choice and Secure Horizons

Would you like us to bill your insurance today: If **YES**, please present insurance card to staff upon completion of this form.  YES  NO

If **YES**, will you be making your co-pay today:  YES  NO

Co-pay Amount: \$

If **NO**, there is a \$15 suggested donation. If you are unable to donate that amount, any amount you can make is appreciated. Would you like to make a donation today:  YES  NO

Donation Amount: \$

*Checks are accepted and should be made payable to PCHD.*

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. INITIAL: \_\_\_\_\_

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 insurance benefits be made directly to the Polk County Health Department. I understand if insurance does not cover services that I will receive a bill for services.

SIGNATURE (or Legal Representative if patient is under 18 years): \_\_\_\_\_ DATE: \_\_\_\_\_

**STAFF USE ONLY**

COPY FRONT OF INSURANCE CARD HERE

COPY BACK OF INSURANCE CARD HERE

COPY FRONT OF SUPPLEMENTAL INSURANCE CARD HERE

COPY BACK OF SUPPLEMENTAL INSURANCE CARD HERE

**VFC eligibility (18 years and under):**

**YES:**  No Insurance  Under Insured  Medicaid Enrolled  Native American/Alaskan Native **NO:**  Privately insured with vaccine coverage

**INFLUENZA – VIS Date: 7/02/2012**

- Vaccine Administration (3yrs+): 90471
- 6 – 35 months: 90657
- 6 – 35 months (preservative free): 90655
- Fluzone Intradermal Q 90654
- Flulaval – Q2036
- Fluzone High Dose Q90662
- Fluzone – Q2038
- NOS – Q2039
- FluMist – 90660 & 90473
- Dosage:  0.25cc IM  0.50cc IM  0.1cc ID
- Site of Injection:  RD  LD  RA  LA  RT  LT
- Manufacturer:
- Lot #:
- Expiration Date:

**PNEUMONIA – VIS Date: 10/06/2009**

- CPT Code: 90732 & 90471
- Dosage: 0.50cc IM
- Site of Injection:  RD  LD  RT  LT
- Manufacturer:
- Lot #:
- Expiration Date:
- TDAP:**
- V20.1 CPT 90715
- Lot# \_\_\_\_\_ GSK Sanofi Pasteur
- Exp. \_\_\_\_\_
- LD
- RD
- VIS Date: 01/24/2012

**Check appropriate diagnosis code below:**

Flu or FluMist: V04.81

Pneumonia Only: V03.82

Flu and Pneumonia: V06.6

**STAFF SIGNATURE:**

**DATE/VIS GIVEN:**