



POLK COUNTY HEALTH DEPARTMENT INFLUENZA CONSENT

PC3

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

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

SECTION A

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

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

PHONE: (\_\_\_\_)\_\_\_\_-\_\_\_\_ BIRTHDATE:\_\_\_\_/\_\_\_\_/\_\_\_\_ AGE:\_\_\_\_\_ GENDER:  MALE  FEMALE

SECTION B

- 1. Any long- term health problem- ex: heart, kidney, lung disease (asthma), diabetes, anemia? YES NO
2. Are you allergic to eggs or Thimerosal (mercury containing preservative used in vaccines)? YES NO
3. Ever had an allergic reaction/other problem after a vaccination(shortness of breath, hives, etc.) YES NO
4. Have you ever had Guillian Barre Syndrome? YES NO
5. Do you feel ill today or have an elevated temperature over 100.1 degrees? YES NO

SECTION C

COMPLETE ONLY IF WANTING FLU-MIST AGE 2-49

- 1. Any long- term health problem- ex: heart, kidney, lung disease ( asthma), diabetes, anemia? YES NO
2. Weakened immune system because of HIV/ Aides or other disorders or treatments like steroids or cancer treatments? YES NO
3. Live with/have close contact with anyone- severely weakened immune system requiring care in a protective environment? YES NO
4. Under 17 yrs old and take salicylates (aspirin)? YES NO
5. Received any live vaccine (Chickenpox, MMR, Shingles, Yellow Fever) in past 4 weeks? YES NO
6. Are you pregnant or could become pregnant within the next month? YES NO

SECTION D

HEALTH INSURANCE INFORMATION

Do you have health insurance YES  NO

If YES-Please list name of insurance plan:\_\_\_\_\_ (WE DO NOT ACCEPT COVENTRY INSURANCE)

We will file your claim with the insurance plans that we participate in. If you have a co- pay, you will be billed at a later date. Please have card ready to scan. If uninsured & 19 years and older, a \$20 fee applies. Unable to pay the full amount? Any amount is appreciated!

AMOUNT PAID: \_\_\_\_\_

SECTION E

18 YEARS & UNDER

Are you Underinsured? (Plan does NOT cover vaccinations) YES NO

Are you Native American/Alaskan Native? YES NO

Are you uninsured? (No insurance) YES NO

Answer "YES" to any of the above, a \$19 administration fee applies. Unable to pay full amount? Any amount is appreciated!

Are you 6 months to 18 years with Medicaid? YES NO

We will bill your Medicaid insurance for the admin fee.

I acknowledge receipt of the "Notice of Health Information Privacy Practices" for Polk County Health Department and understand all information is confidential/can only be released with my consent. I have received and have had the opportunity to read the information sheet for the flu vaccination and have opportunity to ask questions. I understand the benefits and risks of the vaccination. I authorize the healthcare providers of the Polk County Health Dept. I understand if insurance does not cover the services that I will receive a bill for those services.

SIGNATURE : \_\_\_\_\_

DATE: \_\_\_\_\_



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

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

\*\*\*\*\* FORSTAFF ONLY \*\*\*\*\*

INFLUENZA- VIS DATE: 08/19/2014  Injectable Administration ( 3+ yrs): 90471 V04.81

Nasal Administration: 90473 V04.81

6-35 months (0.25ml) Trivalent 90657

Fluzone (0.5ml) Trivalent 90658/Medicare Q2038  
**Preferred for 19-64 y & Healthy >64y**

6-35 months (0.25ml) Quadrivalent 90687  
**Preferred**

Fluzone (0.5ml) Quadrivalent 90688  
**Preferred for 18y and under**

6-35 months Prefilled Quadrivalent 90685  
**Only available in VFC**

Fluzone *High Dose* 90662  
**Preferred for 65 and older chronic conditions  
YES to Section B #1**

FluMist 90672  
**Healthy 2-49y**

DOSAGE:  .25 ML IM  .50 ML IM SITE:  RD  LD  RT  LT  Bilateral Nares

MANUFACTURER: \_\_\_\_\_

LOT #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

PNEUMONIA- VIS Date: 10/6/2009 CPT Code: 90732 & 90471 V03.82

Dosage: .50 ML IM

Site of Injection:  RD  LD

Manufacturer: \_\_\_\_\_

Lot # \_\_\_\_\_

Expiration Date: \_\_\_\_\_

STAFF SIGNATURE: \_\_\_\_\_

**OFFICE USE ONLY**

**ZIP** \_\_\_\_\_

**TRACKING** \_\_\_\_\_

**IRIS** \_\_\_\_\_