



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 _____