



POLK COUNTY HEALTH DEPARTMENT INFLUENZA CONSENT

PC3

CLINIC SITE: _____

CLERK INITIALS: _____

SECTION A

FIRST NAME _____ LASTNAME: _____ MI: _____

PHONE: (____)____-____ BIRTHDATE:____/____/____ AGE:____ GENDER: MALE FEMALE

ADDRESS: _____ CITY: _____ STATE: _____

ZIP: _____

SECTION B

- 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? shortness of breath, hives ect) ? YES NO
3. Have you ever had Guillian Barre Syndrome? YES NO
4. Do you feel ill today or have an elevated temperature over 100.1 degrees? YES NO

SECTION C

HEALTH INSURANCE INFORMATION

Please check appropriate box describing your insurance coverage. 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. WE DO NOT ACCEPT COVENTRY INSURANCE

If uninsured or underinsured child skip to VFC section

GENERAL

- Blue Cross and Blue Shield plans Multi Plan – PHCS Network
 Medicare / Railroad Medicare plans Humana plans Midlands Choice Network
 United Healthcare Network (EXCEPT Tricare plan)
 19 yrs or older and Uninsured the fee is \$ 20.00 19yrs and older with OTHER insurance – the fee is \$ 20.00

VFC SECTION Complete if the patient is 18 years and under only

VFC

- Are you underinsured? (your plan does NOT cover vaccinations) Are you Native American / Alaskan Native

- Are you uninsured? (No insurance)

If you checked one of the three boxes above, a \$19.00 administration fee applies. If you are unable to pay the full amount, any amount that you can pay is appreciated

- Are you 6 months to 18 yrs with Medicaid? We will bill your Medicaid insurance for the administration fee.

SECTION D ONLY COMPLETE QUESTIONS BELOW IF AGES 2-49 AND WANTING THE FLU MIST VACCINE

- 1. Do you have a long- term health problem such as heart disease, lung disease (asthma),kidney disease, diabetes, and anemia? YES NO
2. Do you have a weakened immune system because of HIV/ Aides or other disorders or treatments like steroids or cancer treatments YES NO
3. Do you live with or have close contact with anyone with a severely weakened immune system requiring care in a protective environment? YES NO
4. Are you under 17 yrs old and take salicylates (aspirin)? YES NO
5. Have you received an MMR (measles, mumps, rubella) AND / OR Varicella (chicken pox) vaccine in the last 4 weeks? YES NO
6. Are you pregnant or could become pregnant within the next month? YES NO

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. 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: _____



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FORSTAFF ONLY

INFLUENZA- VIS DATE: 07/26/2013 Injectable Administration (3+ yrs): 90471 V04.81

Nasal Administration: 90473 V04.81

6-35 months 90657

6-35 months (preservative free): 90655

Flu zone *Intradermal* 90654

FluMist 90660

Fluzone 2038

Fluzone *High Dose* 90662

DOSAGE: .25 ML IM .50 ML IM .1ML ID

SITE: RD LD RA LA RT LT Bilateral Nares

MANUFACTURER: _____

LOT #: _____

Expiration Date: _____

PNEUMONIA- VIS Date: 10/6/2009 CPT Code: 90732 & 90471 V03.82 TDAP- VIS Date: 5/9/2013 V20.1 CPT Code: 90715

Dosage: .50 ML IM

Dosage: .50 ML IM

Site of Injection: RD LD

Site of Injection: RD LD

Manufacturer: _____

Manufacturer: _____

Lot # _____

Lot # _____

Expiration Date: _____

Expiration Date: _____

STAFF SIGNATURE: _____

DATE/ VIS GIVEN: _____