INFLUENZA VACCINE ADMINISTRATION

Name: _____ **Phone: (____) _____**
(Last) (First) (MI)

Address: _____
(Street) (City) (State) (Zip)

☐ **Male** ☐ **Female** **Date of Birth:** ____/____/____ **Age:** _____ _____
Township

How did you hear about this flu clinic? (Check all that apply)

☐ Newspaper ☐ Radio ☐ Website ☐ School/Work ☐ Family/Friend ☐ Facebook/Twitter ☐ Other _____

I have received a copy and have read or had read to me the information contained in the appropriate Vaccine Information Statement (VIS) about the vaccine(s) I am requesting. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) indicated on this record be given to me or the person named above for whom I am authorized to make this request. I have received a copy of the Lorain County General Health District (LCGHD) Privacy Statement.

LCGHD participates in the Ohio immunization registry known as Impact - SIIS. Today's record of immunization will be entered in Impact - SIIS and LCGHD's electronic health record (EHR). This information is kept confidential and is shared only with health care providers, your insurance company, and agencies for the sole purpose of protecting your health and that of others. The information shared includes your name, birth date, types of vaccines, and the dates they were given.

In Jurisdiction clients:

In the event that my insurance does not reimburse LCGHD or my employer is not covering the fee for vaccine, I understand that I am receiving a vaccine at no cost by funds provided by the taxpayers through levy funding. If I do not have insurance, I understand I am receiving vaccine provided by the State of Ohio, and levy funding will pay for the administration fee.

Out of Jurisdiction clients:

In the event that my insurance does not reimburse LCGHD or my employer is not covering the fee for vaccine, I understand that I am responsible for the fee and will be billed by LCGHD for any balance due. If I do not have insurance, I understand I am receiving vaccine provided by the State of Ohio and will only pay for vaccine administration if I can afford to do so.

SIGNATURE: _____ **DATE:** _____
(Parent or guardian's signature if client under 18 years of age)

PRINT NAME: _____

FOR CLERICAL USE ONLY

Please indicate form of payment and insurance below (circle one):

Medicaid **Medicare**	**None** **Private Ins.**	**Check**	**Cash**	**No Charge**	**Levy**

ID copied (circle one): **Yes** **No** **Clinic Location:**

FOR NURSING USE ONLY

Vaccine: **Lot # and Expiration Date:**

Route (circle one): **R Del** **L Del** **R Thigh** **L Thigh**

Influenza VIS (08/07/2015) given : ☐

Signature of vaccine administrator:

_____ **Date:** _____

INSURANCE INFORMATION - CONSENT FORM

Print all information below

Client Name: (Last, First) **Birth Date:** ☐ **Male** ☐ **Female**

Address: **City:** **State:** **Zip:**

Primary Insurance: ☐ Aetna ☐ Anthem BCBS ☐ Buckeye ☐ CareSource ☐ Humana ☐ Medicaid ☐ Medical Mutual ☐ Molina ☐ Paramount ☐ UHC Community ☐ United Healthcare ☐ Medicare ☐ None ☐ Other:

Primary Insurance Holder Name:

Birth Date: / / ☐ **Male** ☐ **Female**

Client Relationship to Primary Insurance Holder: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other:**

Secondary Insurance: ☐ Aetna ☐ Anthem BCBS ☐ Buckeye ☐ CareSource ☐ Humana ☐ Medicaid ☐ Medical Mutual ☐ Molina ☐ Paramount ☐ UHC Community ☐ United Healthcare ☐ Medicare ☐ None ☐ Other:

Secondary Insurance Holder Name:

Birth Date: / / ☐ **Male** ☐ **Female**

Client Relationship to Secondary Insurance Holder: ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other:**

This consent is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to let you know your rights to privacy with respect to your health care information.

I give my consent to the Lorain County General Health District (LCGHD) to use and disclose my protected health information for the purposes of treatment, payment, and operations of my health care and this clinic.

Consent for release of information for payment and operations: I authorize the LCGHD to give information to the identified insurance carriers(s) for any and all payment activities.

Consent related to Privacy Notice: I have received a copy of the LCGHD Privacy Notice as part of my initial registration process. I understand that the terms of the Privacy Notice may change, and I may get these change notices by contacting LCGHD by phone or in writing. I understand I have the right to ask how my protected health information will be used and/or given out.

Consent for assignment of benefits: I consent to make all payments for the services given today to the LCGHD. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be stated to be my responsibility by the insurance agency, as required by any contract with my insurance agency and state regulation. I also understand that my contract with my insurance agency may or may not cover some services. It is my responsibility to get information from my health insurance agency about services that are covered. If I get care outside of my health insurance plan, I am aware that I may be responsible for all charges that may be due. A returned check fee of $10.00 will be made to your client account for a check returned for insufficient funds, stopped payment or closed account.

Signature: _____ **Date:** _____

Phone numbers: Mobile _____ **Home** _____

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

patient name _____

date of birth ___/___/_____
month day year

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your health care provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

form completed by _____ date ___/___/___

form reviewed by _____ date _____

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota · 651-647-9009 · www.immunize.org · www.vaccineinformation.org

www.immunize.org/catg.d/p4066.pdf · Item #P4066 (8/15)