WAYNE COUNTY HEALTH DEPARTMENT

FLU VACCINE ADMINISTRATION AND CONTRAINDICATIONS

Office Use Only:		
Manufacturer: GSK Seqirus Sanofi Pasteur	***PRIVATE STOCK:*** **Vaccine Type Given:**	***VFC / CHIP ELIGIBLE: (18 & Under)*** ***ADULT 317 ELIGIBLE (19 & Up)*** **Vaccine Type Given:**
Site Given: RA LA RT LT	**Lot #:**	**Lot #:**

	PAYMENT SOURCE: Check All Applicable			**VACCINE STOCK: Check One**
	3rd Party	Charge to:		VFC - Medicaid Title 19
	Cash / Check	$		VFC - Uninsured or Underinsured (circle one)
	Debit / Credit	$		CHIP - Medicaid Title 21 / State Funded
	Insurance	Insurance Coverage:		State Provided 317 Vaccine (Adult Uninsured / Underinsured)
	Medicaid	Medicaid #		Private

*****ATTACH COPY OF INSURANCE CARD AND/OR MEDI PRINTOUT*****

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (PLEASE PRINT)

NAME:	DATE OF BIRTH:	AGE:	SEX:
ADDRESS:	CITY:	STATE:	ZIP:
PHONE:	PHYSICIAN:		
RACE: (Circle one) American Indian/Alaska Native, Asian, African-American, Hispanic/Latino, Native Hawaiian/Other Pacific Islander, White, Other Race or Unknown	ETHNICITY: (Circle one) Hispanic/Latino, Not Hispanic/Latino, Unknown		

If patient is under the age of 9 AND this is the first time ever receiving a seasonal flu shot OR this is their second year of seasonal flu shots, but they did not receive two doses last year, two doses of flu vaccine is recommended administered one month apart.

PLEASE REVIEW THE FOLLOWING:

Note to patients: WCHD will bill your Insurance/Medicare Part B. If your claim is denied, you will be billed for the flu shot.

- I have read or have had explained to me the information in the Vaccine Information Sheet about influenza and influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.
- I, the undersigned, voluntarily agree to have the influenza vaccine given to me (or the person named above). **The person receiving this vaccine is in good health at this time and is not allergic to chicken egg products, gelatin, polymyxin, neomycin or Thimerosal**. I understand that a physician consult is necessary prior to taking the vaccine for persons who have a history of Guillain-Barre syndrome, or have ever had a serious allergic reaction or other problems after getting an influenza vaccination.
- I will not hold Wayne County Health Department or the nurse giving the vaccine responsible for any adverse reaction that may result from this vaccination.
- I authorize the release of any information necessary to process a Medicare, Medicaid or Insurance claim if applicable. I request payment of benefits to Wayne County Health Department.
- I give the Wayne County Health Department permission to release said flu information to any requesting Physician/Medical Facility/School/Daycare/Employer/Insurance Provider, should said request be made.
- I have been given the opportunity to review the Notice of Privacy Practices.

I have read and understand the above information, and I have had the opportunity to ask questions about the information.

Signature or Parent/Legal Guardian's if under age 18: ______________________________ Date: ________________

Nurse providing the Immunizations: ______________________________ Date: ________________

Please note: The CDC recommends that you wait 15 minutes after receiving any immunizations.
If you experience any problems, please notify a staff member immediately.