



Location: _____

Patient # _____

(Above is clinic use only)

THOMAS COUNTY HEALTH DEPARTMENT

2023 – 2024 OFF-SITE INACTIVE FLU VACCINE ADMINISTRATION RECORD

I have read or have had read to me the Influenza VACCINE INFORMATION STATEMENT for the vaccine I have requested. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine listed below be given to me or to the person named below for whom I am authorized to make this request. I have completed and signed the Screening Questionnaire below for influenza vaccine. I UNDERSTAND AND HAVE BEEN GIVEN A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR THE WORTH COUNTY HEALTH DEPARTMENT.

I acknowledge I have been advised to remain in a designated area for at least 15 minutes after receiving the vaccine for observation of possible reaction. PLEASE INITIAL HERE. _____

For BCBS, UHC, CIGNA, Ambetter and AETNA/COVENTRY: We are now able to bill these insurance companies for immunization services. When you provide us with your insurance information, we will make every attempt to bill your insurance company. In the event that the service is not covered or is denied, you will be mailed a bill along with a copy of the Explanation of Benefits (EOB). At that time, you will be expected to make payment for the service you received. By initialing here _____ you agree to pay for service or balance of the service after insurance payment.

PATIENT INFORMATION (PLEASE PRINT)			
NAME: Last	First	MI	DOB:
ADDRESS:		RACE: (circle one) Black White Other (Specify) _____	
CITY/ STATE/ZIP CODE:		SEX: M F Hispanic: Y N	
ALLERGIES:		PHONE NUMBER:	
METHOD OF PAYMENT (please circle one): Cash, Check, Medicaid, Medicare, Blue Cross/Blue Shield, Ambetter, Cigna, United Healthcare, Aetna/Coventry?			
Policy # _____		Group # _____	
For Medicare Beneficiaries with part B: By signing this form you authorize the release of any medical or other information necessary to process this claim. You also request payment of government benefits either to yourself or the party who accepts assignment. You authorize payment of medical benefits to the Thomas County Board of Health for services described.			
For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child a 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 healthcare provider to explain it.			
1. Is the person to be vaccinated sick today? Yes or No			
If Yes, Explain: _____			
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine? Yes or No			
If Yes, Explain: _____			
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? Yes or No			
If Yes, Explain: _____			
4. Has the person to be vaccinated ever had Guillain-Barré syndrome? Yes or No			
If Yes, Explain: _____			
FOR CLINIC USE ONLY:			
Vaccine Given: _____		Site of Injection: (circle site used)	
VIS Date: _____		IM: Left Deltoid / Right Deltoid	
Date Vaccinated: _____		Left Middle Thigh / Right Middle Thigh	
Manufacturer: _____ Lot #: _____			
_____		_____	
Patient / Parent Signature		Administered By	
Date		Date	