galion city
HEALTH DEPARTMENT

FLU VACCINE ADMINISTRATION FORM

TO BE COMPLETED BY PATIENT *PLEASE COMPLETE BACK*

PATIENT LAST NAME | PATIENT FIRST NAME | DATE OF BIRTH (MM/DD/YEAR) -- -- | AGE

STREET ADDRESS | APT/SUITE | CITY | STATE | ZIP

PHONE NUMBER

GENDER: ☐ Male ☐ Female

PAYMENT AND INSURANCE INFORMATION

Choose method of payment: If using insurance as payment, **all current insurance** carriers must be listed and **all** requested information must be given (Use back or separate page if necessary).

☐ **Insurance (Complete below)** ☐ **Cash** ☐ **Check #** _____ (Make checks payable to Galion City Health Department)

Insurance Type: ☐ **Private Insurance** (through employment or privately purchased) ☐ **Medicaid** (through Job & Family Services)

☐ **Medicare: Railroad Medicare?** ☐ **Yes** ☐ **No** (through Social Security Administration)

Traditional Medicare #: _____ ***Also, if you have a Medicare PPO/MMO list it below**

Insurance Company Name: _____ Member #/ID#/Billing #: _____

Group #: _____ Insured's Name: _____

Insured's DOB: -- -- Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent

****Note: Children 18 years and younger with Medicaid, with NO insurance, or who are underinsured (per VFC guidelines) are eligible for flu vaccine through the VFC program. Adults with no insurance are eligible through the 317 program to receive a vaccine at a reduced cost. Those with private insurance that covers flu shots must pay the normal fee for the vaccine or bill their insurance. There is a discount on the administration fee for those paying at the time of service.**

AUTHORIZATION and CONSENT

Consent for Use of Protected Health Information & Claims Assignment: I hereby consent to the use and disclosure of my personal health information for the immunizations, along with the assignment of all payment from the providers listed above to the Galion City Health Department. **Vaccine Authorization:** My signature on this form indicates that I have requested that the vaccine indicated below be administered to me. I relieve the personnel of the Galion City Health Department of any liability for any reactions that should occur. I have read or have had explained to me the information on this form. **If consenting for another:** I have the legal authority, based on my relationship to the individual indicated above, to consent to this vaccine administration. I understand I will be responsible for the below vaccine(s), that these services are not free, and that nonpayment by the insurance company or patient will result in collections for the amount due. I further understand that I am responsible for any co-pays, co-insurance, and/or deductibles required by my insurance carrier. I have received a copy of the Vaccine Information Statement(s) regarding the diseases and vaccines.

Signature: _____ Date: _____

Relationship to patient: _____

For Health Department Use Only

Vaccination Details: ☐ **317/VFC** ☐ Fluzone **VFC** (90686) $0 ☐ Fluarix **317** (90686) $0 ☐ FluMist **VFC** (90672) $0

☐ **Private** ☐ Fluzone (90686) $31 ☐ Fluarix (90686) $30 ☐ Afluria (90688) $29 ☐ Fluad 65+ (90694) $63

Administration Details: ☐ Administration for 317/VFC with TOS Discount (90460) $15 ☐ FluMist (90672) $37

☐ Administration with TOS Discount (90460/90471/G0008) $5

☐ Administration (90460/90471/G0008) $25

MFR	Lot #	Site	VIS Date	Provider Signature	Date
		☐ LD ☐ LT ☐ RD ☐ RT			

☐ Impact ☐ Group Impact ☐ Billed

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Patient Name: _____

Date of Birth: ____/____/____
month day year

Please complete the section for **Inactivated Injectable Influenza Vaccination*:***

	yes	no	don't know
1. Is the patient 65 years of age or older?	☐	☐	☐
2. Is the patient sick today?	☐	☐	☐
3. Does the patient have an allergy to eggs or to a component of the vaccine?	☐	☐	☐
4. Has the patient ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
5. Has the patient ever had Guillain-Barré syndrome?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Please complete the section for a ***Live Attenuated Intranasal Influenza Vaccination:***

	yes	no	don't know
1. Is the patient sick today?	☐	☐	☐
2. Does the patient have an allergy to a component of the vaccine?	☐	☐	☐
3. Has the patient ever had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Is the person to be vaccinated younger than 2 years or older than 49 years?	☐	☐	☐
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or have a cochlear implant or spinal fluid leak, or no spleen?	☐	☐	☐
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma?	☐	☐	☐
7. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problems; or, in the past 3 months, have they taken any medication that affect the immune system (e.g., prednisone or other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or anticancer drugs) or have they had radiation treatments?	☐	☐	☐
8. Is the person to be vaccinated receiving influenza antiviral medication?	☐	☐	☐
9. Is the person to be vaccinated a child or teen age 6 months through 17 years and receiving aspirin or salicylate-containing medicine?	☐	☐	☐
10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	☐	☐	☐
11. Has the patient ever had Guillain-Barré syndrome?	☐	☐	☐
12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐	☐	☐
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____