

**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 IIV4 VFC (90686) \$0  Fluarix 317 (90686) \$0  FluMist VFC (90672) \$0  
 Private  Fluzone IIV4 (90686) \$32  FluMist (90672) \$35  HD 65+ (90662) \$73

**Administration Details:**  Administration for 317/VFC with TOS Discount (90460) \$15  
 Administration with TOS Discount (90460/90471/G0008) \$5  
 Administration (90460/90471/G0008) \$25

MFR	Lot #	Site	VIS Date	Provider Signature	Date
		<input type="checkbox"/> LD <input type="checkbox"/> LT <input type="checkbox"/> RD <input type="checkbox"/> RT			

Note Signed  Superbill Signed  Charged

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the patient sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the patient have an allergy to eggs or to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the patient ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the patient ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient have an allergy to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the patient ever had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the person to be vaccinated younger than 2 years or older than 49 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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, or metabolic disease (e.g., diabetes)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the person to be vaccinated have <b>a</b> ) an open channel between the cerebrospinal fluid (CSF) and the mouth, throat, nose or ear or any other cranial CSF leak, or <b>b</b> ) a cochlear implant, or <b>c</b> ) an immunocompromising condition due to any cause (e.g. medication ,congenital or acquired immunodeficiency, HIV infection, or a missing or non-functioning spleen [e.g. caused by sickle cell disease])?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the person to be vaccinated receiving influenza antiviral medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the person to be vaccinated a child or teen age 6 months through 17 years and receiving aspirin or salicylate-containing medicine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the patient ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: \_\_\_\_\_

Date: \_\_\_\_\_

Form reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_