galion city
HEALTH DEPARTMENT

FLU VACCINE ADMINISTRATION FORM

TO BE COMPLETED BY PATIENT

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 ☐ Dependant

****Note: Only 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. 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: ☐ **Public/VFC** ☐ Quad .5 (90686) $0

☐ **Private** ☐ Quad .5 (90686) $29 ☐ HD (90662) $58 ☐ Flublok (90682) $58

Administration Details: ☐ Administration for Public/VFC with Time of Service Payment Discount (90460) $15

☐ Administration with Time of Service Payment 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

Galion City Health Department • 113 Harding Way East • Galion, OH 44833 • 419-468-1075

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Patient Name: _____

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

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

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

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____