Date of Service / / 16

TCHD FLU SHOT ENCOUNTER FORM

PRINT CLEARLY

Client's Name:_____ **Date of Birth:** _____ **Age:** _____

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email address: _____

Race: _____ **Ethnicity:** ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** **Sex:** ☐ **Male** ☐ **Female**

Primary Insurance Info: _____

Secondary Insurance Info: _____

If client is a minor: Parent/Guardian Name: _____

COMPLETE FOR PERSON RECEIVING FLU SHOT:

Notify the Nurse if you answer "Yes" to any of the questions.	**Yes**	**No**
1. Are they sick today? (They **CAN** receive vaccine if they are taking antibiotics or have a mild illness such as an ear infection, cold, fever or diarrhea.)	☐	☐
2. Have they had a severe allergic reaction (e.g. anaphylaxis) to a previous dose of vaccine, a vaccine component, including egg protein, or to latex?	☐	☐
3. Have they had a severe reaction to a vaccine, (i.e., within 6 weeks of receiving a flu vaccine, have they had muscle weakness and paralysis, diagnosed as Guillain-Barré syndrome)?	☐	☐
4. Answer only if they are 6 months thru 8 years of age: **Have they had < 2 flu vaccines?**	☐	☐

COMPLETE IF PERSON IS RECEIVING ADDITIONAL VACCINE:	**Yes**	**No**
1. Have they had a nervous system problem, a seizure, or a parent or sibling with seizures?	☐	☐
2. Are they pregnant or could become pregnant during the next month?	☐	☐
3. Have they received any other vaccinations in the past four weeks?	☐	☐
4. Have they had a transfusion of blood, blood products or immune globulin in the past year?	☐	☐
5. Do they have cancer, leukemia, HIV/AIDS or other immune system problems?	☐	☐
6. In the past 3 months, have they taken drugs that affect the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐

Informed Medical Consent: I voluntarily consent/request for myself or the person I am legally responsible for, to vaccine(s). I have been given a copy of and have read, or had explained to me, the information contained in the VIS(s) about the disease(s) and vaccine(s) and understand the benefits and risks of the vaccine(s). I agree that this information may be shared with schools, day care centers, health care providers, and others to verify immunization status, for public health studies, or when medically necessary. I hereby release TCHD and their employees from all claims arising from such immunizations. **Billing:** I understand, as a courtesy to me, TCHD will bill my Medicaid/Medicare/Insurance and I hereby authorize them to do so. I understand I am responsible for any and all charges incurred if my insurance company denies payment for services rendered. If TCHD does not have a contract to bill my insurance company or if I do not have medical insurance, I understand I am responsible for payment in-full at the time of service. **HIPAA:** I am aware of TCHD's Notice of Privacy Practices, had an opportunity to ask questions and at my request, may receive a copy.

Signature of Client/Parent/Guardian: _____ **Date:** _____

DO NOT COMPLETE BELOW THIS LINE:

INSURANCE: ☐**Medicaid** ☐**CHIP** ☐**PCN** ☐**Medicare** ☐**Private:**

VFC ELIGIBILITY: ☐**Not VFC Eligible** ☐**VFC Medicaid** ☐**VFC Uninsured** **Paid $:**

VACCINE	LOT	Site	Price	VACCINE	LOT	Site	Price
☐**INFLUENZA High Dose 65+**			**$ 62**	☐**PPV 23** 65+/19-64 hi-risk			**$ 88**
☐ **INFLUENZA Quad Inject 3+**			**$ 40**	☐**Tdap 7+** (☐Td 7+ $45)			**$ 61**
☐ **INFLUENZA Inject** 6-35 mos			**$ 40**	☐**Zostavax 50+**			**$210**
☐**PCV 13 0-2, 50+**			**$147**				

☐**A Royal, RN** ☐**L Heap, RN** ☐**L Ekenstam, RN** ☐**M Bateman, RN**