

DATE OF SERVICE: _____ / _____ / _____

TCHD FLU SHOT ENCOUNTER FORM

PRINT CLEARLY OR COMPLETE ON-LINE AND PRINT FORM

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: _____

ANSWER FOR PERSON RECEIVING FLU SHOT: (If YES, discuss with Nurse.) YES NO

1. Are they sick today? (They CAN receive vaccine if they have only a mild illness, such as an ear infection, cold, fever or diarrhea, or are taking antibiotics.)	<input type="checkbox"/>	<input type="checkbox"/>
2. Have they had a severe reaction to vaccine, (i.e., within 6 weeks of receiving a flu vaccine, have they had muscle weakness and paralysis diagnosed as Guillain- Barré Syndrome)?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do they have any severe allergies, (medications, food, egg protein, vaccine components, latex, etc.)? Please list:	<input type="checkbox"/>	<input type="checkbox"/>
4. Are they 8 or younger and have never received a flu vaccine or received only 1 flu vaccine?	<input type="checkbox"/>	<input type="checkbox"/>

ANSWER IF RECEIVING ADDITIONAL VACCINE(S): (If YES, discuss with Nurse.) YES NO

1. Have they had a nervous system problem, a seizure, or a parent or sibling with seizures?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do they have cancer, leukemia, HIV/AIDS or other immune system problems.	<input type="checkbox"/>	<input type="checkbox"/>
3. 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?	<input type="checkbox"/>	<input type="checkbox"/>
4. In the past year, have they had a transfusion of blood, blood products or immune globulin?	<input type="checkbox"/>	<input type="checkbox"/>
5. In the past four weeks, have they received any other vaccines? Please list:	<input type="checkbox"/>	<input type="checkbox"/>
6. Are they pregnant or could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>

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.

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

DO NOT COMPLETE BELOW THIS LINE

<input type="checkbox"/> Insured		<input type="checkbox"/> Not VFC Eligible		<input type="checkbox"/> VFC Medicaid		<input type="checkbox"/> VFC Uninsured		Paid \$:	
VACCINE	LOT	Site	Price	VACCINE	LOT	Site	Price		
<input type="checkbox"/> INFLUENZA High Dose, 65+			\$40	<input type="checkbox"/> PCV 13 0-2, 50+			\$194		
<input type="checkbox"/> INFLUENZA Quad Inject, 3+			\$40	<input type="checkbox"/> PPV 23, 65+/19-64 hi-risk			\$110		
<input type="checkbox"/> INFLUENZA Inject, 6-35 mos			\$40	<input type="checkbox"/> Tdap, 7+			\$61		
<input type="checkbox"/> Hep A/Hep B, TWINRIX 18+			\$62	<input type="checkbox"/> Zostavax, 50+			\$210		

A Royal, RN G Powelson, RN W Lyman, RN L Heap, RN L Ekenstam, RN M Bateman, RN

*If client is uninsured, a \$10 discount will be given for cash payment.