DATE OF SERVICE:_____/_____/____

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: _____

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.)	☐	☐
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)?	☐	☐
3. Do they have any severe allergies, (medications, food, egg protein, vaccine components, latex, etc.)? Please list:	☐	☐
4. Are they 8 or younger and have never received a flu vaccine or received only 1 flu vaccine?	☐	☐
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?	☐	☐
2. Do they have cancer, leukemia, HIV/AIDS or other immune system problems.	☐	☐
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?	☐	☐
4. In the past year, have they had a transfusion of blood, blood products or immune globulin?	☐	☐
5. In the past four weeks, have they received any other vaccines? Please list:	☐	☐
6. Are they pregnant or could become pregnant during the next month?	☐	☐

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

☐Insured ☐Not VFC Eligible ☐VFC Medicaid ☐VFC Uninsured Paid $:

VACCINE	LOT	Site	Price	VACCINE	LOT	Site	Price
☐**INFLUENZA High Dose,** 65+			**$62**	☐**PCV 13** 0-2, 50+			**$194**
☐**INFLUENZA Quad Inject,** 3+			**$40**	☐**PPV 23,** 65+/19-64 hi-risk			**$110**
☐**INFLUENZA Inject,** 6-35 mos			**$40**	☐**Tdap,** 7+			**$61**
☐**Hep A/Hep B,** TWINRIX 18+			**$97**	☐**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.

Revised 10-25-17mb