

TCHD FLU ENCOUNTER

DATE OF SERVICE: _____ **INS** **VFC MCD** **VFC UNINSURED**

Name: _____ Date of Birth: _____ Age: _____ Sex: M/F

Address: _____ City _____ State _____ Zip _____

Phone: _____ Cell Phone: _____ Race: _____

Primary Insurance: _____ ID/Policy #: _____

Secondary Insurance: _____ ID/Policy #: _____

Complete for person receiving the vaccine:

Yes No

- Are you sick today?
- Has had a serious allergy to any foods or medications.
- Has had a serious reaction to a vaccine in the past.
- Is on aspirin therapy, chemo/radiation therapy.
- Has been paralyzed by Guillain-Barre Syndrome, had a seizure or nervous system problem?
- Has had immunizations in the last month.
- Has been sick in the last week, on an antibiotic or antiviral medication.
- Is pregnant, or has a chronic illness such as heart disease, lung disease, diabetes, asthma, kidney or liver disease, anemia or other blood disorder.
- Do you or anyone you live with have a weakened immune system?

I have been given a copy and have read, or had explained to me, the information contained in the Vaccine Information Statement about the disease and vaccine. I understand the benefits and risks of the vaccine and request that the vaccine be given to me or the person for whom I am authorized to make this request. I agree that this information may be shared with schools, daycare centers, healthcare providers and others when medically necessary. I have been given a copy of the Tooele County Health Department's Notice of Privacy Practices and have had a chance to ask questions about how my public health information will be used. I understand that it is my responsibility to know what my insurance plan covers and agree to pay the portion not covered by my insurance. I understand that if Tooele County Health Department does not have a contract with my insurance company, or my insurance company denies payment, I am responsible for all charges incurred.

Client/Guardian Signature: _____ Date: _____

*** Space below for Public Health Nursing Information Only ***

X	Vaccine	Lot #	Site	Price
	Influenza FluMist 2-49		T D L R	40
	Influenza Quadrivalent Flu 3+		T D L R	40
	Influenza Flublock 18+		T D L R	75
	Influenza High Dose		T D L R	75
	Twinrix		T D L R	133
	PPV 23, Pneumovax		T D L R	135
	PCV 13, Prevnar, 0-2 & 50+		T D L R	227
	Tdap, 7+		T D L R	61
	Shingrix		T D L R	176

Amount Paid \$ _____ Nurse: _____ Clerk: _____