

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:

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you sick today? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has had a serious allergy to any foods or medications. |
| <input type="checkbox"/> | <input type="checkbox"/> | Has had a serious reaction to a vaccine in the past. |
| <input type="checkbox"/> | <input type="checkbox"/> | Is on aspirin therapy, chemo/radiation therapy. |
| <input type="checkbox"/> | <input type="checkbox"/> | Has been paralyzed by Guillain-Barre Syndrome, had a seizure or nervous system problem? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has had immunizations in the last month. |
| <input type="checkbox"/> | <input type="checkbox"/> | Has been sick in the last week, on an antibiotic or antiviral medication. |
| <input type="checkbox"/> | <input type="checkbox"/> | Is pregnant, or has a chronic illness such as heart disease, lung disease, diabetes, asthma, kidney or liver disease, anemia or other blood disorder. |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 High Dose 65+		T D L R	84
	COVID		T D L R	
	Twinrix		T D L R	123
	PPV 23, Pneumovax		T D L R	135
	PCV 13, Prevnar, 0-2 & 50+		T D L R	249
	Tdap, 7+		T D L R	67
	Shingrix		T D L R	196

Amount Paid \$ _____ Nurse: _____ Clerk: _____