Shelby County Health Department
1600 SR 44, Suite B
Shelbyville, IN 46167
Public Health

SEASONAL QUADRIVALENT PRESERVATIVE FREE INFLUENZA VACCINATION

PATIENT INFORMATION:

Patient _____ Gender___ DOB __/__/___ Phone Number _____Cell/txt : Land
Email_____ RACE_____ Maiden Name_____

Address _____City/State/ Zip Code

INSURANCE INFO: Medicaid Medicare Work Insurance Marketplace No Health Insurance (***circle all that apply***)

Insurance Company Name _____ Policy Holder *(Insured's Name)*_____

Policy Holder's Date of Birth ___/___/_____ Policy Number:_____ Group Number _____

Employer: _____ Medicare ID#: _____ Pt's Physician_____

1. Is the person to be vaccinated currently ill? Explain: _____
   ☐ Yes ☐ No
2. Has the person to be vaccinated ever had an allergic reaction or other problem after a flu vaccination?
   ☐ Yes ☐ No
3. Has the person to be vaccinated ever had Guillain-Barre Syndrome?
   ☐ Yes ☐ No
4. Has the person to be vaccinated had an allergy to eggs, chicken products, gelatin, or latex?
   ☐ Yes ☐ No
5. Are you Pregnant? _____
6. I acknowledge it is recommended I stay in the clinic 15 minutes post vaccination to lower risk of injury from fainting. ☐ Yes

CONSENT TO TREAT: I authorize Shelby County Health Department to administer treatment as deemed necessary for care of the patient named above. I certify that I am the patient, parent or legal guardian of the patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment. I hold Shelby County, the Shelby County Health Department and its employees harmless from any and all liability as a result of this treatment and appointment. I understand it is my responsibility as legal consenter to decline any vaccination when I return this form to Nursing Staff. **I understand if I decline a vaccine after I sign and return this form it may result in being charged for the cost of any opened and unused vaccine and supplies.**

ASSIGNMENT OF BENEFITS: All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. Including but not limited to Teletask, CHIRP and Vaxcare databases. The patient/parent/responsible party is responsible for any unpaid balances. Co-Payments will be made at the time of service. I request that payment of authorized Medicare, Medicaid, or other insurance company benefits be made to Shelby County Health Department or VaxCare as indicated for any services furnished to me by the Shelby County Health Department. Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

RECEIPT OF THE NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been given an opportunity to read the Notice of Practices for the Shelby County Health Department and to have any questions answered before signing.

RECEIPT/REVIEW OF THE VACCINE INFORMATION SHEETS (VIS): I acknowledge that I have been given an opportunity to review, have take home copies of VIS available upon request, and I have been given an opportunity to have any questions answered before signing.

My signature indicates agreement to the above and that all information provided above is true and accurate:

_____ _____

Signature of Patient or Legal Representative *Print Name* *Date*

Staff use only

6mo THRU 18 19+ (MHS) 19+ (Un or Underinsured)

VaxCare **High Dose 65+** **VFC** 2BB77 **SC $$** **317Adult**

FluBlok 18+

Route: IM Site: Right T / D or Left T / D HPV Hep A PCV13 PPSV23 Tdap Shingrix

Admin/Review by: _____ _____ CHIRP VaxCare INMed

Date Vaccinated & VIS Provided