LOCATION: _ ___Thomas County School PATIENT #____________

THOMAS COUNTY HEALTH DEPARTMENT
OFF-SITE VACCINE ADMINISTRATION RECORD
2017 - 2018

I have read or have had read to me the VACCINE INFORMATION STATEMENT for the flu vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine listed below be given to me or to the person named below for whom I am authorized to make this request. I have completed and signed the Screening Questionnaire below for influenza vaccine. I UNDERSTAND AND HAVE BEEN GIVEN A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR THE THOMAS COUNTY HEALTH DEPARTMENT.

I acknowledge I have been advised to remain in a designated area for at least 15 minutes after receiving the vaccine for observation of possible reaction. PLEASE INITIAL HERE. _________

For BCBS, UHC, CIGNA and AETNA/COVENTRY: We are now able to bill these insurance companies for immunization services. When you provide us with your insurance information, we will make every attempt to bill your insurance company. In the event that the service is not covered or is denied, you will be mailed a bill along with a copy of the Explanation of Benefits (EOB). At that time you will be expected to make payment for the service you received. By initialing here _______ you agree to pay for service or balance of the service after insurance payment.

PATIENT INFORMATION (PLEASE PRINT)	
NAME: Last First MI	**DOB:**
ADDRESS: **CITY/ STATE/ZIP CODE:**	**RACE: (circle one)** **Black White Other (Specify)__________** **SEX: M F Hispanic: Y N**
ALLERGIES:	**PHONE NUMBER:**

METHOD OF PAYMENT**: Cash, Check, Medicaid, Medicare, Blue Cross/Blue Shield, Aetna/Coventry, Cigna, United Healthcare? Policy # _________________ Group # _________________**

For Medicare Beneficiaries with part B:By signing this form you authorize the release of any medical or other information necessary to process this claim. You also request payment of government benefits either to yourself or the party who accepts assignment. You authorize payment of medical benefits to the Thomas County Board of Health for services described.

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child a vaccination today. If you answer “yes” to any question, it does not necessarily mean you or your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Are you sick today? Yes No
2. Are you allergic to eggs or any component of the vaccine? Yes No
3. Have you ever had a serious reaction to the flu vaccine in the past? Yes No
4. Have you ever had Guillain-Barre syndrome? Yes No

FOR CLINIC USE ONLY:

Vaccine Given: ______________________ VIS Date: __________________________ Date Vaccinated: ____________________ Manufacturer & Lot #: ___________________	Site of Injection: (circle site used) IM –Left Deltoid/Right Deltoid Left Middle Thigh/Right Middle Thigh
______________________________ __________ PATIENT/PARENT SIGNATURE DATE	________________________ _________ ADMINISTERED BY DATE

Revised 08/15/2017