Putnam County Health Department
Influenza (Flu) Vaccine Administration Record

Patient Name _____ **Date of Birth** _____

Address _____ **City** _____ **ST** ____ **ZIP** _____

Phone #_____ **Age** ____ **Male**____ **Female** ____ **Physician** _____

Please answer the following questions about the person to receive the vaccine:	**No**	**Yes**
• Are you sick today?		
• Have any allergies to eggs, latex, Mercury, gelatin or other vaccine co component?		
• Serious reaction to influenza vaccine in the past?		
• History of Guillain-Barre syndrome?		

Consent related to privacy notice: I have had a chance to review the Privacy Notice as part of this registration process. I understand the Terms of the Privacy Notice may change and I may get these changed notices by contacting PCHD by phone or in writing. I understand I have the right to ask how my protected health information will be used and/or given out.
A copy of the Privacy statement is displayed in the waiting area, and a copy can be given if requested by client. For off-site flu clinics, a copy is available, if requested, upon client registration.

I have received a copy of the Influenza Vaccine Information statement. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I give permission for my name and birthdate to be released to state and federal Government for required reporting purposes.

Signature of person to receive vaccine or person authorized to make the request (Parent or Guardian)	**Date**

For office use only:

Vaccine Manufacturer	Vaccine Lot #	Date Administered	Admin. Site	Dosage	Nurse Signature
			Lt. Deltoid IM	0.25 mL	
			Rt.Deltoid IM	0.5 mL	
			Lt. Thigh IM		
			Rt. Thigh IM		

Please complete the following information if you have any type of insurance coverage:

(Skip this section if we are not billing an insurance plan.)

Medicaid Billing ID Number _____ **Group Number** _____
Name of Medicaid Managed Care Company _____

Medicare Billing ID# _____ **Group Number** (if any)_____
Name of Medicare Provider/Company _____

Primary Insurance Coverage
Name of Insurance Company _____
Name of person on card _____
Address of Insurance Company_____
ID # on insurance card _____Group # on insurance card_____
Birthdate of card holder _____
Address of card holder_____

Secondary Insurance Coverage
Name of Insurance Company _____
Name of person on card _____
Address of Insurance Company_____
ID # on insurance card _____Group # on insurance card_____
Birthdate of card holder _____
Address of card holder_____

Consent for release of information for payment and operations: I authorize PCHD to give information to the identified insurance carrier(s) for any and all payment activities.

Consent for assignment of benefits: I give permission for my insurance to be billed and acknowledge I am financially responsible for the patient responsibility according to my insurance guidelines. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other amounts that may be stated to be my responsibility by the insurance agency, as required by any contract with my insurance agency and state regulation. I also understand that my contract with my insurance agency may or may not cover some services. It is my responsibility to get information from my health insurance agency about services that are not covered. If I get care outside of my health insurance plan, I am aware that I may be responsible for all charges that may be due.
By signing this consent, I authorize the use and/or disclosure of my health information for treatment, payment or health care operations.

Signature _____ Date _____

……

OR:
I ***do not*** give permission for my insurance agency to be billed for services. My services & fees will be paid by myself or employer.

Signature _____ Date _____

……

OR:
I do not have insurance coverage for myself _____ I do not have insurance coverage for my child _____

Signature _____ Date _____