

Kanawha-Charleston Health Department

108 Lee Street, East
Charleston WV 25301

2011-2012 Seasonal Influenza Vaccination Consent/Administration Form

Name _____
(Last) (First) (Middle Initial)

Mailing Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Gender M F Marital Status _____ Race _____
Month/Day/Year (optional)

Home Phone # _____ Cell Phone # _____ Work Phone # _____

	Yes	No
Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>
Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Has the person to be vaccinated ever had a serious reaction to influenza vaccine the past?	<input type="checkbox"/>	<input type="checkbox"/>
Has the person to be vaccinated ever had Guillain-Barré Syndrome (GBS)?	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE TURN PAGE OVER AND COMPLETE OTHER SIDE

HEALTH DEPARTMENT USE ONLY

Influenza Manufacturer: GSK
LOT NUMBER
INJECTION SITE

Influenza Manufacturer: Sanofi
LOT NUMBER
INJECTION SITE

Influenza – Intranasal Manufacturer: MedImmune 2 – 49 years
LOT NUMBER
INJECTION SITE

Pneumococcal (PPSV) Manufacturer: Merck
LOT NUMBER
INJECTION SITE

Vaccinator Signature

Date

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

The KCHD Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice of Privacy Practices is subject to change. A copy of our Notice, is available upon request. By signing this form, you acknowledge that the KCHD Notice of Privacy Practices was made available to you.

CONSENT

You must be at least 18 years of age to sign. If under age 18, a parent or guardian’s signature is required. I have read or had explained to me the Vaccine Information Statement(s) for the 2011-12 Influenza vaccine and/or Pneumococcal vaccine and understand the risks and benefits. Vaccine Information Statements (VIS Forms) have been made available to me and I understand the information about the vaccine(s).

PAYMENT INFORMATION

Option 1: Pay the day of the clinic. Cash, check, (Lee Street ONLY MasterCard, VISA, and Discover credit/debit card) payments may be made on the day of the clinic.

Option 2: Bill Insurance. Kanawha-Charleston Health Department can bill the insurances listed below for the immunizations. I request that payment of authorized third party (including Medicare) benefits be made to Kanawha-Charleston Health Department for services furnished by the Department. Submission of insurance information does not guarantee coverage. I understand that if the insurance company does not cover the vaccine(s), I will be responsible for payment.

Please indicate your method of payment Option 1
 Option 2 - complete the following:

- | | | |
|--|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Aetna Medicare | <input type="checkbox"/> CHIPs | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Blue Cross | <input type="checkbox"/> Freedom Blue | <input type="checkbox"/> PEIA |
| <input type="checkbox"/> Carelink | <input type="checkbox"/> Humana | <input type="checkbox"/> UMWA |
| <input type="checkbox"/> Carelink Medicaid | <input type="checkbox"/> Medicare | <input type="checkbox"/> Unicare |
| <input type="checkbox"/> Other _____ | | <input type="checkbox"/> WellCare |

Policy Holder’s Name _____
(Last) (First) (Middle Initial)

Patient Relationship to Policy Holder Self Spouse Child Other(describe) _____

Policy Holder Date of Birth: _____ Policy ID Number: _____ Group # (if any) _____

Patient/Patient Representative’s Signature

Date

Health Department Use Only – Patient Pay

Amount Paid _____ Cash Check Check # _____

Receipt # _____ Receipt issued by _____