

**Kanawha-Charleston Health Department**

108 Lee Street, East, Charleston, West Virginia 25301

Tax ID#55-6011142

[Empty box for Company]

**Company**

[Empty box for Receipt #]

**Receipt #**

**VACCINE ADMINISTRATION RECORD**

Last Name	First Name	Middle Initial	Birthdate
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Street Address	City	State	Zip
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Last 4 Digits of Social Sec.No	Age	Telephone	Marital Status	Sex
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Employer	Employer Phone
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**HEALTH DEPARTMENT USE ONLY**

**INFLUENZA 6-35 mo.**  
Manufacturer: Sanofi Pasteur

\_\_\_\_\_  
LOT #

\_\_\_\_\_  
INJECTION SITE

**INFLUENZA 4+**  
Manufacturer: Novartis

\_\_\_\_\_  
LOT #

\_\_\_\_\_  
INJECTION SITE

**INFLUENZA - PF 3+**  
Manufacturer: Sanofi Pasteur

\_\_\_\_\_  
LOT #

\_\_\_\_\_  
INJECTION SITE

SIGNATURE OF VACCINE ADMINISTRATOR

Date Administered

**PAYMENT INFORMATION**

**Private Pay**

Paid Amount [ ]

Check [ ] Cash [ ]

Check # \_\_\_\_\_

**Medicare Part B**  RR

ID# [ ]

PEIA  Carelink

ID# [ ]

<input type="checkbox"/> Carelink Medicaid	<input type="checkbox"/> Straight Medicaid
<input type="checkbox"/> Unicare Medicaid	<input type="checkbox"/> CHIPS
<input type="checkbox"/> Blue Cross	<input type="checkbox"/> Freedom Blue
<input type="checkbox"/> Humana	<input type="checkbox"/> Wellcare
<input type="checkbox"/> Advantra Freedom	<input type="checkbox"/> UMWA

ID# [ ]

**INFLUENZA VACCINE**

"I have read or have had explained to me the information in the printed material furnished to me about Influenza and Influenza Vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of Influenza vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request."

X \_\_\_\_\_  
Signature of Patient or Patient's Representative Date

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

In General, any information that is about your health, the health care you receive, or payment for that care is considered confidential and protected by the health information to carry out treatment, payment, healthcare operations, and/or other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures. Please sign below to acknowledge that a copy of our Notice of Privacy Practices was made available to you.

X \_\_\_\_\_  
Signature of Patient or Patient's Representative Date

**PATIENT'S AUTHORIZATION TO BILL INSURANCE**

"I request that payment of authorized third party (including Medicare) benefits be made to Kanawha-Charleston Health Department for services furnished by the Department. I authorize release to the Health Care Financing Administration and any other third party payment source involved in this transaction and their agents any medical information needed to determine eligibility for payment pursuant to services received this date by me or by the person named above for whom I am authorized to make this request."

X \_\_\_\_\_  
Signature of Patient or Patient's Representative Date

**PNEUMOCOCCAL VACCINE**

"I have read or have had explained to me the information in the printed material furnished to me about Pneumococcal disease and Pneumococcal polysaccharide 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 Pneumococcal vaccine and request that the vaccine given to me or to the person named above for whom I am authorized to make this request."

X \_\_\_\_\_  
Signature of Patient or Patient's Representative Date