HarveyCounty

HARVEY COUNTY HEALTH DEPARTMENT **Influenza Registration Form**

CLIENT INFORMATION: Legal Last: _____ Legal First: _____ MI: _____

Birth Date: _____ SS#: _____

Address: _____ City: _____State:_____ Zip Code:_____

Telephone: H (___)_____ Cell (___)_____ Work (___)_____

School: _____ E-Mail, if over age 18: _____

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Sex: □ Male □ Female **Marital Status:** □ Single □ Married □ Widowed

Race: □White □ Asian □Black/African Am. □Am. Indian □Native Hawaiian/Pacific Islander □ Other

Ethnicity: □Hispanic □Non-Hispanic

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PARENT/GUARDIAN INFORMATION (if client is under 18):

If your child is under 9 years of age and getting the flu shot for the first time or has only had the flu shot once before in their lifetime then they will need two doses of the flu vaccine spaced 4 weeks apart.

Last: _____ First:_____ MI:_____ Birth Date: _____

Address: _____ City: _____State:_____ Zip Code:_____

Telephone: H (___)_____ Cell (___)_____ Work (___)_____

SS#_____ E-Mail:_____

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Payment or arrangements must be made before the vaccination will be given. How do you plan to pay?

If not filing insurance, please contact us at 316-283-1637 to discuss payment.

□ I will pay full fee today. Cash or check. Make check out to the Harvey Co Health Dept.
□ I wish to apply for a reduced fee. My family's **gross** income is _____ per _____. (Please use your most current IRS Form 1040 Adjusted Gross Income if you filed taxes.) Number in household: _____.
□ Bill private health insurance plan. Insurance card/information must be presented prior to or at time of service.
Policyholder's Name: _____ Policyholder's DOB: _____
Insurance Name: _____ Member ID:_____
□ Bill KanCare and/or Medicaid. Insurance card/information must be presented prior to or at time of service.
Child's Name as it appears on card: _____ Insurance Name:_____
Insurance ID#: _____

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Please read and check each box that applies before signing.

□ I give consent for the person named above to receive the requested vaccination.
□ I authorize immunizations for the person named above be sent to his/her school upon request.
□ I request a copy of the Vaccination Information Statement be presented at time of service.
□ I request a copy of the Health Department's Notice of Privacy Practices to be presented at time of service.
□ I request payment of insurance benefits to the Harvey County Health Dept.
□ I authorize the release of only the medical or billing information necessary to process claims for insurance providers including Medicare or Medicaid.
□ I agree to be fully responsible for any co-pay, deductible or non-covered services.

_____ _____ _____
Signature of Client or Responsible Party Relationship to Client Date

For the client to receive any vaccine, all questions on the back must be answered.

HarveyCounty

For the client to receive any vaccine, all questions must be answered.

1. Does the client have any known allergies? YES NO

   If so, please list:_____

2. Has the person to be vaccinated ever had a reaction to vaccinations (shots) before? YES NO

   If so, please describe:_____

3. Has the client received any vaccine within 30 days before today? YES NO

4. Has the client ever received an influenza (Flu) vaccine? YES NO

5. Has the client ever had a reaction to an influenza (Flu) vaccination? YES NO

   If so, please describe:_____

6. Has the client ever had Guillian-Barre syndrome (a form of paralysis)? YES NO

7. Does the client have asthma, recurrent wheezing, or active wheezing? YES NO

8. Is the person to be vaccinated currently sick or experiencing a high fever? YES NO

9. Does the client have any of the following:
   a. Kidney Disease? YES NO
   b. Heart Disease? YES NO
   c. Blood Disorder? YES NO
   d. Metabolic diseases (e.g. diabetes)? YES NO
   e. Any disease that lowers the body's resistance to infection? YES NO

10. Is the client taking steroids, arthritis medication, chemotherapy or recently completed a course of steroids? YES NO

11. Has the person to be vaccinated had a seizure, convulsions or other neurological problem? YES NO

12. Will the client have close contact with anyone who has a weakened immune system and requires care in a protective environment? YES NO

13. Is the client pregnant, nursing, or thinking of becoming pregnant within the next three months? YES NO

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FOR CLINIC USE ONLY

VACCINE	EXT	SITE	ROUTE	VIS DATE	DOSE	MANUFACTURER, LOT #, EXP DATE
Influenza	RT LT	Deltoid Vastus Lat	IM	8/15/19		

_____ _____

Signature and Title of Vaccine Administrator Date