PLEASE PRINT **ADULT FORM (19 and older)** **Office Use only: Client ID#_____**

Macomb County Health Department Seasonal Influenza Vaccine Program **Date:_____ Time:_____**

Birthdate: _____ Social Security # (last 4 digits) ___ ___ ___ ___ Medicare #: _____

Legal Name: _____
(Last Name) (First Name) (Middle Name)

Street Address: _____City:_____ State:_____ Zip: _____ County:_____

Telephone #_____ Sex (Circle One): Male Female

Are you enrolled in any of the following? (check all that apply) ____ **Medicare Part B** ____ **Medicaid** ____ **No Medical Insurance**

____ Commercial Insurance that **does** cover immunizations (circle) **BCBS OF MI BCN HAP MCLAREN PRIORITY OTHER**_____

____ Commercial Insurance that **does not** cover immunizations_____

THIS SECTION TO BE COMPLETED ONLY BY VALID MEDICARE PART B CARD HOLDERS and/or COMMERCIAL INSURANCES ACCEPTED BY MACOMB COUNTY HEALTH DEPARTMENT:
I authorize any holder of medical information about me to release to Medicare and/or my commercial insurance or their Intermediaries or carriers, information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment below.

Signature X_____ Macomb County Health Department Accepts Assignment

Medical Screening Questionnaire and Consent for Vaccination

*Please **circle** the answer to the following questions about you or the person to be vaccinated:*

(Use for Community Outreach Settings only)
Medical Screener:
_____(initials/3 digit ID)
(Include MCHD Staff 3 digit ID)
□ Denied Reason:
_____

YES **NO** 1. Have you ever had a serious reaction to a vaccine?
YES **NO** 2. Are you allergic to eggs, Thimerosal, gelatin, latex or any antibiotics?
YES **NO** 3. Have you received an influenza vaccination before?
YES **NO** 4. Have you ever had Guillain-Barré Syndrome (GBS)?
YES **NO** 5. Do you have any long-term health problem such as heart or lung disease, kidney disease or metabolic disease (diabetes)?
YES **NO** 6. Are you a current smoker?
YES **NO** 7. Do you have severe thrombocytopenia (low platelet count) or a bleeding disorder?
YES **NO** 8. Are you currently ill or running a fever?
YES **NO** 9. Do you have asthma or have you had a recent episode of wheezing in the past 12 months?
YES **NO** 10. Are you or do you think you may be pregnant?
YES **NO** 11. Have you received any vaccine within the past 30 days?
YES **NO** 12. Do you have cancer, leukemia, lymphoma, or any immune deficiency disease (inability to fight infection) or are you currently receiving chemotherapy, radiation therapy or steroid therapy (prednisone or cortisone)?
YES **NO** 13. Do you have close contact with anyone who has a severely weakened immune system (for example, an individual who has had a bone marrow transplant and is currently in a hospital isolation room)?

I have read or have had explained to me, the information contained in the Vaccine Information Statement(s) regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Macomb County Health Department to release my immunization record information, or the immunization record information of the person for whom I am authorized to make this request to other health care provider(s) as needed.

Macomb County Health Department Notice of Health Information Practices

I have received a copy of Macomb County Health Department's Notice of Health Information Practices.
I understand that my acknowledgement of the Notice is evidenced by my signature on this document.
The Department is required to abide by the terms of this privacy notice. The Department may change the terms of its notice at any time. The new notice will be effective for all protected health information that it maintains at that time. Upon my request, the Department will provide me with the revised notice of privacy practices.

X_____ _____
SIGNATURE of Client/Legal Guardian PRINT NAME of Legal Guardian (if applicable)

_____**Received Notice of Health Information Practices** _____**REFUSED written acknowledgement** 9-7-18 Adult

THIS SIDE OF FORM TO BE COMPLETED BY MACOMB COUNTY HEALTH DEPT STAFF ONLY

MCHD OFFICE STAFF USE ONLY: **Date of Service:**_____

____ Medicare ____ Self Pay MC (01) _____ Client ID _____

____ Medicaid ____ No Pay (Waived/250) WRN (02) _____ SCS (03) _____ (91/92/93)Facility Zip Code_____

Does client have ___BCBS OF MICHIGAN ___BCN ___HAP ___MCLAREN ___PRIORITY ___OTHER_____

Nurse Staff ID _____ Nurse Confirmation of Client's Birthdate: _____

Vaccine	Mfg/Lot#	Route	Site (Circle One)	VIS Date	VIS Given
FLQ (IIV4)	_____	IM	RT LT RD LD	08/07/2015	_____
FLVQ (IIV4)	_____	IM	RT LT RD LD	08/07/2015	_____
FLHD (IIV3) CP (65 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/07/2015	_____
FLUA (aIIV3) CP (65 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/07/2015	_____
FLCX (ccIIV4) CP (4 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/07/2015	_____
FLBQ (RIV4) CP (18 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/07/2015	_____
PP23	_____	SC IM	RA LA RD LD	04/24/2015	_____
TDP	_____	IM	RT LT RD LD	02/24/2015	_____
Td	_____	IM	RT LT RD LD	02/24/2015	_____
PCV13	_____	IM	RT LT RD LD	11/5/2015	_____
Hep A	_____	IM	RT LT RD LD	7/20/2016	_____
_____	_____	IM	RT LT RD LD	_____	_____

Progress Notes: _____

_____

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Please copy Medicare Part B card or MEDICAID card/commercial insurance cards and driver's license below.
(If Medicare Part A only, do not copy Medicare card; client becomes self pay client)