

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

Birthdate: _____ Sex (circle one): Male or Female

Legal Name: _____

Street Address: _____
(Last Name) (First Name) (Middle Name)

City: _____ State: _____

Zip: _____ County: _____

Telephone #: _____

<p>OFFICE USE ONLY <input type="checkbox"/> Paying by Credit Card</p> <p>Is Cardholder Name Correct? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Cardholder Name: _____</p> <p>If NO, list correct Name: _____</p>

<p>Are you enrolled in any of the following?</p> <p>___ Medicare part B ___ Medicaid ___ No Medical Insurance</p> <p>___ Commercial Insurance that does covers immunizations</p> <p>(Circle) BCBS of MI BCN HAP</p> <p>MCLAREN PRIORITY OTHER _____</p> <p>___ Commercial Insurance that does not cover immunizations.</p>
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Medicare/Medicaid/Insurance #: _____

Medical Screening Questionnaire and Consent for Vaccination

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

- 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 and to other public health authorities (e.g., for entry into an immunization registry for influenza reporting requirements).

<p>IN REGARDS TO VALID MEDICARE PART B CARD HOLDERS and/or COMMERCIAL INSURANCES ACCEPTED BY MACOMB COUNTY HEALTH DEPARTMENT:</p> <p>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.</p>
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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.

By signing below, I hereby acknowledge that I have read and fully understand the applicable statements above.

X _____
SIGNATURE of Client/Legal Guardian

PRINT NAME of Legal Guardian (if applicable)

_____**Received Notice of Health Information Practices** _____**REFUSED written acknowledgement** 8-12-20 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: _____

<u>Vaccine Given</u>	<u>Mfg/Lot#</u>	<u>Route</u>	<u>Site</u> (Circle One)	<u>VIS Date</u>	<u>VIS</u>
FLVQ (IIV4) CP or STATE _____	_____	IM	RT LT RD LD	08/15/2019	_____
FLQ (IIV4) CP or STATE _____	_____	IM	RT LT RD LD	08/15/2019	_____
FLHQ (IIV4) CP (65 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/15/2019	_____
FLCX (ccIIV4) CP or STATE (4 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/15/2019	_____
FLBQ (RIV4) CP or STATE (18 YEARS AND OLDER)	_____	IM	RT LT RD LD	08/15/2019	_____
FLMQ (LAIV4) CP or state _____	_____	IN (intranasal)	IN	08/15/2019	_____

Progress Notes: _____

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)