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

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

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

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

Street Address: _____

City: _____ State:_____ Zip:_____ County: _____

Telephone #: _____

Are you enrolled in any of the following?
___Medicare Part B ___ Medicaid ___ No Medical Insurance
___ Commercial Insurance that **does** covers immunizations
(Circle) BCBS of MI BCN HAP
MCLAREN PRIORITY OTHER _____
___ Commercial Insurance that **does not** cover immunizations.

OFFICE USE ONLY ☐ Paying by Credit Card
Is Cardholder Name Correct? ☐ YES ☐ NO
Cardholder Name:_____
If NO, list correct Name:
_____

Medicare/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 ever had Guillain-Barré Syndrome (GBS)?
YES **NO** 4. Do you have severe thrombocytopenia (low platelet count) or a bleeding disorder?
YES **NO** 5. Are you currently ill or running a fever?

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).

IN REGARDS TO 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.

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 Drive-up

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 Given	**Mfg/Lot#**	**Route**	**Site** (Circle One)	**VIS Date**	**VIS**
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	_____

Progress Notes: _____

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8-12-20 ADULT Drive-up