HARVEY COUNTY HEALTH DEPT INFLUENZA & PNEUMONIA REGISTRATION FORM

CLIENT INFORMATION:

Last: _____ First: _____ MI: _____

Birth Date: _____ SSN (age 18 & over, for internal use only):_____

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

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

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):

Last: _____ First:_____ MI:_____

Birth Date: _____ SSN:_____

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

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

E-Mail:_____

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For clients age 18 years and under only: Check one below.

☐Private insurance ☐KanCare ☐ Medicaid ☐No insurance ☐Insurance does not cover immunizations
☐Children are school age **and** enrolled in Free or Reduced Lunch Program (proof must be provided).

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

☐ I will pay full fee for flu or for pneumonia today. Cash, check or card. 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 recent IRS Form 1040 Adjusted Gross Income if you filed taxes.) Number in household: _____.
☐ Bill private health insurance plan. Insurance card must be presented at time of service.
Policyholder's Name: _____ Policyholder's DOB: _____
☐ Bill Medicare. Card must be presented at time of service.
☐ Bill KanCare and/or Medicaid. Insurance card must be presented at time of service.

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Please read and check each box that applies before signing.

☐ I request the vaccines to be given to the person named above for whom I am authorized to make this request.
☐ I have been offered the Vaccination Information Statement(s). I have read or have had the information explained to me. My questions have been answered satisfactorily.
☐ I acknowledge that I have been offered a copy of Health Department's Notice of Privacy Practices with the effective date of September 12, 2013.
☐ 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 vaccines, all questions on the back must be answered.

Please circle your preferred method of influenza vaccine. **Flu shot** **Flu mist**

Does the client have any known allergies to food or medicine? _____YES _____NO
If yes, to what? _____

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FOR THE FLU VACCINE, please answer the following questions:

Has the client received any vaccine within 30 days before today?	NO	YES
Has the client ever received an influenza vaccine?	NO	YES
Has the client ever had a reaction to an influenza vaccination?	NO	YES
Has the client ever had Guillian-Barre syndrome (a form of paralysis)?	NO	YES
Does the client have severe allergy to eggs, egg protein, gentamicin, gelatin or arginine?	NO	YES
Does the client have an allergy to latex?	NO	YES
Does the client have asthma, recurrent wheezing (if under 5), active wheezing?	NO	YES
Is the client receiving aspirin or aspirin-containing treatment (if under 18)?	NO	YES
Does the client have any of the following:		
kidney disease?	NO	YES
heart disease?	NO	YES
metabolic diseases (e.g. diabetes)?	NO	YES
Any disease that lowers the body's resistance to infection?	NO	YES
Is the client taking steroids or chemotherapy?	NO	YES
Will the client have close contact with anyone who has a weakened immune system and requires care in a protective environment?	NO	YES
Is the client pregnant or nursing?	NO	YES

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FOR THE PNEUMONIA VACCINE, please answer the following questions:

Has the client ever received pneumonia vaccine?	NO	YES	UNSURE
Is the client 65 or older?	NO	YES	

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FOR CLINIC USE ONLY

Clinic Identification _____ Clinic Date _____

Intramuscular (VIS 08/07/15) age 6m and over

Mfr.	Lot No.	Exp Date
Sanofi Pasteur		
Dosage	Route	Site
0.5mL 0.25mL	IM	LD RD

Intradermal (VIS 08/07/15) age 18y – 64y

Mfr.	Lot No.	Exp Date
Sanofi Pasteur		
Dosage	Route	Site
0.1mL	ID	LD RD

Intranasal (VIS 08/07/15) age 2y – 49y

Mfr.	Lot No.	Exp Date
MedImmune, Inc		
Dosage	Route	Site
0.2mL	Nasal	Nasal

Pne (VIS PPSV 04/24/15, PCV13 02/27/13)

Mfr.	Lot No.	Exp Date
Pfizer Merck		
Dosage	Route	Site
0.5 mL	IM	LD RD

08/24/2015

_____ _____
Signature and Title of Vaccine Administrator Date