



NAME: _____ DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____ SEX: Male Female

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

Please note: Private Aetna cannot be billed through the Franklin County Health Department.

Please Print Name exactly as it appears on Insurance Card _____

Name of Insurance Company _____

Insurance Number _____ Name of Insured _____

Insured's Date of Birth _____ Relationship to the Insured _____

* I have been given a copy of the "Vaccine Information Statement"

YES NO

* I have been offered a copy of the Notice of Privacy Practices with the effective date of September 23, 2013.

YES NO

* I consent to have this immunization be put in the Kansas Immunization Registry

YES NO

- | | | | |
|--|------------------------------|-----------------------------|-------------------------------------|
| 1. Is the person to be vaccinated sick today? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 2. Does the person to be vaccinated have an allergy to eggs or to a component of the eggs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |
| 4. Has the person to be vaccinated ever had Guillain-Barrè syndrome? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |

I understand the benefits and risks of the Influenza (FLU) vaccine and ask the vaccine be given to me or to the person named for whom I am authorized to make this request. Further, I authorize the release of any medical information necessary to process my insurance claim(s) or as needed by my insurance carrier. I authorize and request payment of medical benefits directly to my medical provider. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I am responsible for payment for all services rendered to me or my dependent including any remainder not covered by insurance.

Signature of Patient or Patient Representative

Date

FOR OFFICE USE ONLY		
Clinic Site _____	Date of Injection _____	Injection Site _____
Manufacturer: _____	Lot # _____	Exp Date _____
Signature of Nurse _____		