PUBLIC HEALTH
Franklin
COUNTY KANSAS
EST. 1855

FRANKLIN COUNTY HEALTH DEPARTMENT
1418 S. MAIN ST, SUITE 1
OTTAWA, KANSAS 66067
785-229-3530

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**

1. Is the person to be vaccinated sick today? ❑ **Yes** ❑ **No** ❑ **Don't know**
2. Does the person to be vaccinated have an allergy to eggs or to a component of the eggs? ❑ **Yes** ❑ **No** ❑ **Don't know**
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? ❑ **Yes** ❑ **No** ❑ **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. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named above.

_____ _____

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 _____