Location: _____ Patient #_____

THOMAS COUNTY HEALTH DEPARTMENT
2021 – 2022 OFF-SITE VACCINE ADMINISTRATION RECORD

I have read or have had read to me the Influenza VACCINE INFORMATION STATEMENT 8/6/21 for the vaccine I have requested. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine listed below be given to me or to the person named below for whom I am authorized to make this request. I have completed and signed the Screening Questionnaire below for influenza vaccine. I UNDERSTAND AND HAVE BEEN GIVEN A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR THE THOMAS COUNTY HEALTH DEPARTMENT.

I acknowledge I have been advised to remain in a designated area for at least 15 minutes after receiving the vaccine for observation of possible reaction. PLEASE INITIAL HERE. _____

For BCBS, UHC, CIGNA, Ambetter and AETNA/COVENTRY: We are now able to bill these insurance companies for immunization services. When you provide us with your insurance information, we will make every attempt to bill your insurance company. In the event that the service is not covered or is denied, you will be mailed a bill along with a copy of the Explanation of Benefits (EOB). At that time, you will be expected to make payment for the service you received. **By initialing here _____** you agree to pay for service or balance of the service after insurance payment.

PATIENT INFORMATION (PLEASE PRINT)	
NAME: Last First MI	**DOB:**
ADDRESS: **CITY/ STATE/ZIP CODE:**	**RACE: (circle one)** **Black White Other (Specify)_____** **Hispanic: Y N** **SEX: M F**
PHONE NUMBER:	

METHOD OF PAYMENT (please circle one): **Cash, Check, Medicaid, Medicare, Blue Cross/Blue Shield, Ambetter, Cigna, United Healthcare, Aetna/Coventry?**

Policy # _____ Group # _____

For Medicare Beneficiaries with part B: By signing this form you authorize the release of any medical or other information necessary to process this claim. You also request payment of government benefits either to yourself or the party who accepts assignment. You authorize payment of medical benefits to the **THOMAS County Board of Health** for services described.

Please read and answer the following statement and Screening checklist for Contraindications to Vaccines below:

1. Is the person to be vaccinated sick today? Yes No
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine? Yes No
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? Yes No
4. Has the person to be vaccinated ever had Guillain-Barré syndrome? Yes No
5. Any known allergies? Yes No Explain:

Patient Signature: _____ Date: _____

Nurse Signature: _____ **Date:** _____

Date Administered:	Lot #	Site: IM LD RD

Rev 9/10/21