Emmons County Public Health Nurses will be coming to the school to provide an Influenza Immunization Clinic on Tuesday October 17th from 1:30 to 4:30 pm. Flu Mist is not available. Kindergarten thru 6th grade should have a parent present. If parent is unable to attend, an older sibling may accompany the child but consent form must be completed. 7th– 12th graders may come without a parent if they have a signed consent. The forms can be printed off the school's website. Please bring your insurance card. This event will be open to the public. You can call the public health office with any questions 254-4027.

Public Health
Prevent. Promote. Protect

INFORMATION ABOUT THE PERSON TO RECEIVE THE INFLUENZA VACCINE

Person to be Vaccinated : (Last, First and Middle, required):	Date of Birth:	Age:	Gender: (circle) Male Female

Street Address	PO Box	City/State/Zip Code:	County:

Social Security Number	Hispanic or Latino: Circle Yes No	Race: Please circle White, Asian, America Indian, Black or African American, or Other _____

Birth State	Home Phone #	Cell Phone #	Maiden Name:

INSURANCE INFORMATION

Primary Insurance Company Name ☐ copy of Card ☐ No Insurance	Policy Holder's Name	Policy Holder's Date of Birth

Policy Number or Medicare-Medicaid #	Group Number	Relationship to Client

Tobacco Use (Circle One):	**Current**	**Former**	**Never**	
Second Hand Smoke Exposure	**Home**	**Work**	**None**	
W. Fax Referred to Quitline	**X. Quitline/Quitnet info given**	**Y. SHS info given**		**Z. No action taken**

Questions must be asked prior to immunization administration:

	Yes	No
Do you have any allergies, especially to eggs, Thimerosal or Latex?		
Do you have a fever, cold, or feel ill?		
Have you had a previous reaction from the flu shot?		
Have you received previous immunization within the last 4 weeks		
Are you currently receiving chemotherapy?		
Are you pregnant?		
Have you had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes) asthma, or a blood disorder?		
Are you on long-term aspirin therapy?		
If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?		
Have you ever had Guillain-Barre Syndrome (temporary severe muscle weakness)?		
Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatments with radiation or drugs?		
Do you have close contact with a person who needs care in a protected environment such as someone who has recently had a bone marrow transplant?		

ACKNOWLEDGEMENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS

A copy of the appropriate Centers for Disease Control and Prevention **Vaccine Information Statement(s) has been provided.** I have read, or have had explained, the information about the disease(s) and the vaccine(s) listed. There was an opportunity to ask questions and all questions were answered satisfactorily. I believe that I understand the benefits and risks of the vaccine(s) cited, and **ask that the vaccine(s) listed be given to the person names above (for whom I am authorized to make this request).**

If I am the Client, or an individual legally obligated to pay for medical services provided to the Client or a Guarantor of payment, **I agree to pay and I am financially responsible** for the Local Public Health Unit's established charges provided to the Client no covered by a third-party payer. I assign and **authorize any third party payer/insurer** to make direct payment to the Local Public Health Unit for all benefits payable for the Client's care. *I authorize the release of any medical or other information necessary to process this claim.*

Signature of person to receive vaccine or person authorized to make the request: X	Date

FOR OFFICE USE ONLY:
PLEASE CHECK ALL THAT APPLY

MEDICARE	ROUTE	INJECTION SITE	VACCINE TYPE	CODES	LOT NUMBER
G0008 – 36.00	___ IM ___ IN	___ LA ___ RA	____HIGH DOSE ____REGULAR	___90662 – 45.00 ___90686 – 30.00	

MEDICAID PRIVATE PAY STATE FUNDED	ROUTE	INJECTION SITE	VACCINE TYPE	CODES	LOT NUMBER
90471	___ IM ___ IN	___ LA ___ RA	___ 3+ YRS ___ 0-3 YRS	____ 90686 SD ____ 90688 MD ____ 90685 SD ____ 90687 MD	

DIAGNOSIS CODE FOR ALL: Z23

ADMINISTRATION FEES:	INSURANCE COMPANY	VACCINE FEE:
36.00	**PRIVATE PAY INSURANCE**	30.00
20.99	**MEDICAID**	0.00
36.00	**STATE FUNDED**	0.00

CLINIC SITE: PLEASE CHECK ONE

BRADDOCK HMC	HAGUE HMC	HAZELTON HMC	LINTON HMC	STRASBURG HMC

BAKKER SCHOOL	HMB SCHOOL	LINTON SCHOOL	STRASBURG SCHOOL

OFFICE	OTHER:

RN SIGNATURE	
DATE	