RICHD ADULT FLU CONSENT

FULL NAME: _____

First Name M **Last Name**

DATE OF BIRTH:_____AGE: _____

STATE EMPLOYEE ONLY

STATE EMPLOYEE ONLY: YES___ NO____

LAST 4 OF SS#

CIRCLE GENDER: MALE FEMALE

STREET ADDRESS:_____CITY:_____

STATE:_____ ZIP CODE:_____PHONE NUMBER:_____

CIRCLE RACE: WHITE BLACK/AFRICAN-AMERICAN ASIAN AMERICAN INDIAN OTHER:_____

CIRCLE ETHNICITY: HISPANIC/LATINO NON-HISPANIC/LATINO

CIRCLE PREFERRED LANGUAGE: ENGLISH SPANISH OTHER

INSURANCE PRIMARY:_____ID#_____GROUP#_____

SECONDARY:_____ID#_____GROUP#_____

**Do you have any allergies? (latex or medicines)	**Circle:**	YES	NO
Have you ever had a **REACTION to a flu shot before:	**Circle:**	YES	NO
****Do you currently have an active illness or are your taking antibiotics?**	Circle:	YES	NO
**Have you had Guillain-Barre Syndrome?	Circle:	YES	NO
**Have you traveled outside of the US within the last 30 days?	**Circle:**	YES	NO
****Have you been in contact with anyone who has traveled outside of US within the last 30 days?	Circle:	YES	NO

If you answer "yes" to any of the above questions, please let the nurse know

JOINT NOTICE OF PRIVACY PRACTICES GIVEN

HAVE READ OR HAD THE INFORMATION ABOUT THE INFLUENZA VACCINE EXPLAINED TO ME. I WAS GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I UNDERSTAND THE BENEFITS AND RISKS OF THE INFLUENZA VACCINE AND REQUEST THE VACCINE BE GIVEN TO ME OR THE PERSON FOR WHOM I AM AUTHORIZED TO MAKE THIS REQUEST. I UNDERSTAND THAT THE IMMUNES GIVEN TODAY WILL BE ENTERED INTO THE STATE DATA BASE, UNLESS I DECLINE. THE LAST FOUR DIGITS OF YOUR SOCIAL SECURITY NUMBER IS SO THAT YOUR BILL WHEN SUBMITTED CAN BE READILY IDENTIFIED AND PAID.

X _____

PRINTED NAMED

X_____ _____

SIGNATURE of person receiving vaccine or parent/guardian DATE

. _ .. AGENCY USE ONLY

PP STOCK ONLY

FLU VACCINE

SITE: _____

2024-2025 VIS 8/6/2021- GIVEN _____

FLUZONE HD_____

VACCINE LOT #_____

VACCINE EXP DATE_____

FLUBLOK: _____

VACCINE LOT #_____

VACCINE EXP DATE_____

Office Use Only: BILLING

Clinic Site:_____

Payment:___ _ **cash/check/cc#**_____

Medicare **Private Insurance** IPA Adult

Bill Township_____

Bill County for Employee/dependent: _

State Employee: _

SIGNATURE OF NURSE ADMINISTERING VACCINE_____

8-13-2024

ROCK ISLAND COUNTY HEALTH DEPARTMENT

PRIVATE PAY INSURANCES

BLUE CROSS BLUE SHIELD

AETNA

HUMANA

UNITED HEALTH CARE

CIGNA

HEALTH ALLIANCE

MEDICARE

AMBETTER

WELLMARK

VFC INSURANCES FOR CHILDREN UNDER 19

MEDICAID

MOLINA

MERIDIAN

BLUE CROSS BLUE SHIELD HEALTH PLANS

AMERIGROUP

WELLPOINT

AETNA BETTER HEALTH

IOWA TOTAL CARE

***PEOPLE WHO DO USE INSURANCE (EVEN THOUGH THEY ARE LISTED ABOVE) ARE RESPONSIBLE FOR FINDING OUT IF THEIR INSURANCE COVERS VACCINES AND CONFIRM THAT ROCK ISLAND COUNTY HEALTH DEPARTMENT IS WITHIN NETWORK.

NO HMO INSURANCES ARE ACCEPTED AT THIS HEALTH DEPARTMENT.

STATE EMPLOYEE WORKERS ONLY WE WILL BILL THE STATE DIRECTLY

IF NO INSURANCE THE FEE FOR FLUBLOK AND FOR HIGH DOSE FLU IS $66

8-13-2024