



CALHOUN COUNTY PUBLIC HEALTH DEPARTMENT

2015/2016 FLU FORM

"Working to enhance our community's total well-being"

First Name Middle Initial Last Name

Address

City State Zip Code

AGE BIRTHDATE MM/DD/YYYY MALE FEMALE If female, pregnant Y N

PLEASE SELECT YES OR NO:

- 1. Are you sick today? YES NO
2. Are you allergic to eggs or latex? YES NO
3. Have you received any vaccines within the last 28 days? YES NO
4. Are you receiving chemotherapy, radiation, or immunosuppressive therapy? YES NO
5. Have you ever had any serious reaction to flu vaccine? YES NO
6. Have you ever had Guillain-Barré syndrome, multiple sclerosis, or other neurological illness? YES NO
7. Do you have asthma diagnosed by a physician? YES NO
8. Are you a smoker? YES NO

CALHOUN COUNTY PUBLIC HEALTH DEPARTMENT CONSENT FOR SERVICES 2015/2016 FLU

By signing this Consent for Service(s) Form you:

*are giving your permission for you or your dependents to receive services from the Calhoun County Public Health Department (CCPHD).

*have been offered information sheet(s) regarding the service(s) provided, the benefits, possible side effects, risks, and your responsibilities as a client in receiving this service(s) (where applicable).

*have been offered a copy of the CCPHD Notice of Privacy Practices.

*permit CCPHD staff to disclose your information among other CCPHD programs in accordance with applicable laws and regulations that may include sensitive health information, such as HIV infection, to provide you with the best treatment.

*authorize insurance benefits to be paid directly to CCPHD, authorize the release of pertinent medical information to insurance carrier to the extent permitted by law, and agree to pay non-covered services.

*authorize all immunization information to be submitted to the Michigan Immunization Registry where you will be able to obtain immunization status through a medical provider. (An individual who is 20 years of age or older may request, in writing, that the department make any personal immunization information in the registry inaccessible to other providers.)

All of your information remains confidential and a Client Release of Information must be filled out for each release of information requested for agencies outside of CCPHD except for those uses and activities listed in the Notice of Privacy Practices.

My preferred method of contact is:

Phone Cell/Home _____

Text to above number Y N

Email address _____

Signature Date

**** FOR CLINIC USE ONLY ****

Pt # _____ Clinic Identification _____

VFC (underinsured/uninsured) PRIVATE OTHER _____

Amount Pd: _____ Cash _____ Check# _____ CC _____

ID checked? _____ Medicaid # _____

Active, NOT ESO

Commercial Insurance Info: *Must Have Copy of Insurance Card*

Insured Cardholder:
 Same as front OR

Statement should be sent to:
 Same as front OR

Name:	Name:
Birthdate:	Address:
Relationship to Patient:	Phone:
Employer:	Relationship to Patient:

VFC	Private	
20.00	44.00	FluMist 2-49 years (LAIV)
20.00	41.00	Influenza – prefilled syringes .25 6-35 months Preservative free (IIV4 pf)
20.00	38.00	Influenza – SDV 3 yrs & older - Preservative free (IIV4 pf)
20.00	38.00	Influenza – prefilled syringes .50 - 3 yrs & older preservative free (IIV4 pf)
20.00	36.00	Influenza – MDV – 6 months & older (IIV4)
	52.00	High Dose Flu – 65+ (IIV HD)
20.00	83.00	Pneumococcal – Pneumovax (PPSV23)
20.00	172.00	Pneumococcal – Prevnar (PCV13)

INFLUENZA

Date Vaccinated _____

Manufacturer & Lot # _____

Site of Injection **RA RL LA LL NASAL**

Dose **0.25ml 0.5ml 0.2ml**

Immunizer (int.) _____

COMMENTS/OTHER _____

VIS: 8/7/15

PNEUMOCOCCAL

Pneumonia shot in last 5 years? Yes No

Vaccine Type: PPSV23 PCV13

Date Vaccinated _____

Manufacturer & Lot # _____

Site of Injection **RA RL LA LL**

Immunizer (int.) _____

COMMENTS/OTHER _____

VIS: PPSV23 - 4/24/15 PCV13 – 2/27/13