CALHOUN COUNTY PUBLIC HEALTH DEPARTMENT

190 E. Michigan Avenue
Battle Creek, Michigan 49014
Phone: 269-969-6370
Fax: 269-969-6470
www.calhouncountymi.gov/publichealth

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

First Name **Initial** **Last Name**

Address

City **State, Zip Code**

AGE **BIRTHDATE** ____ / ____ / ____ **MALE** ☐ **FEMALE** ☐

Month Day Year

If female, pregnant? Y ○ N ◉

PLEASE CHECK YES OR NO:

1. Are you sick today?	YES ○	NO ◉
2. Are you allergic to eggs or latex?	YES ○	NO ○
3. Have you ever had any serious reaction to flu vaccine?	YES ○	NO ○
4. Have you ever had Guillain-Barré syndrome, multiple sclerosis, or other neurological illness?	YES ○	NO ○
5. Do you have asthma diagnosed by a physician?	YES ○	NO ○
6. Are you a smoker?	YES ○	NO ○

CALHOUN COUNTY PUBLIC HEALTH DEPARTMENT CONSENT FOR FLU SERVICES

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 the CCPHD except for those uses and activities listed in the Notice of Privacy Practices.

My 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	(SDV – single dose; MDV – Multi dose; PF – preservative free)
23.00	40.00	Influenza – prefilled syringes .25 6-35 months Preservative free (IIV4 PF)
23.00	40.00	Influenza – SDV 3 yrs & older – Preservative free (IIV4PF)
23.00	40.00	Influenza – prefilled syringes .50 – 3 yrs & older preservative free (IIV4PF)
23.00	40.00	Influenza – MDV – 6 months & older (IIV4)
	69.00	FluBlok - SDV - PF 18+
	69.00	High Dose Flue – 65+ (IIV HD)
23.00	116.00	Pneumococcal – Pneumovax (PPSV23)
23.00	203.00	Pneumococcal – Prevnar (PCV13)

INFLUENZA

Date Vaccinated_____

Vaccine Name _____

Vaccine Supply: VFC AVP Private

Manufacturer & Lot #_____

Site of Injection **RA RL LA LL**

Dose **0.25ml 0.5ml**

Immunizer (int.) _____

COMMENTS/OTHER _____

VIS: 8/7/15

PNEUMOCOCCAL

Pneumonia shot in last 5 years?

No_____Yes_____ Date_____

Vaccine Type PPSV23 PCV13

Date Vaccinated _____

Vaccine Name _____

Vaccine Supply: VFC/AVP Private

Manufacturer & Lot # _____

Site of Injection **RA RL LA LL**

Immunizer (int.)_____

COMMENTS/OTHER _____

VIS: PPSV23 - 4/24/15 PCV13 - 11/5/15