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 | **Middle Initial** | **Last Name**

Address

City | **State, Zip Code**

AGE ____ **BIRTHDATE** ____ / ____ / ____ (Month / Day / Year)

MALE ☐ **FEMALE** ☐

If female pregnant (Y) (N)

PLEASE CIRCLE YES OR NO:

1. Are you sick today? YES NO
2. Have you received any vaccines with the last 28 days? YES NO
3. Are you allergic to latex? YES NO
4. Have you ever had any serious reaction to flu vaccine? YES NO
5. Do you have wheezing or asthma in the past 12 months? YES NO
6. Are you or a family member receiving chemotherapy, radiation or immunosuppressive therapy? YES NO
7. Have you ever had Guillain-Barré syndrome, multiple sclerosis, or other neurological illness? YES NO
8. Are you a smoker? YES NO

CALHOUN COUNTY PUBLIC HEALTH DEPARTMENT CONSENT FOR SERVICES 2019/2020 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 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(s) 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. (Upon receipt of a written request from an individual who is 20 years of age or older, the department shall make any immunization information in the registry pertaining to that individual inaccessible.)

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 practice.

Phone number_____

_____

Signature Date

✳✳ FOR CLINIC USE ONLY ✳✳

Pt # _____

VFC (underinsured/uninsured) PRIVATE

Amount Pd: _____ Cash Check#_____ CC

Medicaid #_____

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

Insured Cardholder:

Name:
Birthdate:
Relationship to Patient:
Employer:

VFC	Private	
23.00	43.00	FluMist 2-49 years
23.00	40.00	Influenza – prefilled syringes .25 6-35 months Preservative free
23.00	40.00	Influenza – SDV 3 yrs & older - Preservative free
23.00	40.00	Influenza – prefilled syringes .50 - 3 yrs & older preservative free
23.00	40.00	Influenza – MDV – 6 moths & older
	70.00	FluBlok for 18 years and older
	70.00	High Dose Flu

Clinic location:

INFLUENZA

Date Vaccinated_____

Lot #:_____

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

Dose **0.25ml 0.5ml 0.2ml**

Immunizer (int.) _____

COMMENTS/OTHER_____

PNEUMOCOCCAL

Pneumonia shot in last 5 years?

Yes Date:_____ No

PPSV23 PCV13

Date Vaccinated_____

Lot #:_____

Site of Injection **RA RL LA LL**

Immunizer (int.)_____

COMMENT/SOTHER_____

Tdap	Hep A
Lot #	
Site	