Stanly County Health Department
2009-2010 Influenza Vaccine Consent Form

Patient Name_____ _____ ___ _____ _____ _____
(Please Print) Last First Middle Initial Date of Birth mm/dd/yyyy Sex Race

_____ _____ _____ _____ _____
Address City State Zip County

_____ ☐ Yes ☐ No _____
Home Phone (xxx) xxx-xxxx Hispanic Social Security Number xxx-xx-xxxx

Mother's Maiden Name _____ Mother's first name _____

1. Have you ever had a serious reaction to a flu shot? Yes ☐ No ☐
2. Do you have a fever, cold, or lung infection today? Yes ☐ No ☐
3. Are you allergic to latex? Yes ☐ No ☐
4. Are you allergic to thimerosal (a mercury preservative in vaccines)? Yes ☐ No ☐
5. Do you have a severe allergy to eggs, feathers, or chicken? Yes ☐ No ☐

CONSENT FOR FLU SHOT-NOTICE OF PRIVACY PRACTICE

I agree for Medicare or Medicaid, if applicable, to be billed and I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the Stanly County Health Department. If payment is denied, I agree to be personally responsible for payment. I have read or have had explained to me the information on the Vaccine Information Sheet about the Influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the risks and benefits of influenza vaccine and request that the influenza vaccine be given to me or the person named above for whom I am authorized to make this request. I have been provided access to the Stanly County Health Department Notice of Privacy Practices.

X_____ _____
Signature of recipient or authorized person (*Age 18 and under require parental consent) Date

INFORMATION FOR OFFICE AND CLINICAL USE ONLY

☐ Clinic ☐ Employee
☐ Spring Arbor ☐ Group Home
☐ Woodhaven court ☐ Home Health
☐ Other_____

Place label here

Injection Site: IM Deltoid _____Right _____ Left
Mid-Lateral Thigh_____Right_____Left
VIS: English 08/11/09 Spanish _____

Nurse Signature:_____

MEDICARE PART B / MEDICAID / PVT PAY / NC / VFC
(Circle one)
Effective/Valid Date_____

Number_____

Name Listed as _____

CPT Code: 90658 (>3 yrs) 90657 (6-35 mths)
Admin Code: 90741 Diagnosis Code V04.81

Amt Pd. _____ Cash CK# _____

Date _____/_____/_____ Sec. Initials _____