

**CLAY COUNTY HEALTH DEPT.**

452 Main St., PO Box 36

Clay WV 25043

**2010-11 Seasonal Influenza and Pneumonoccal Vaccination Consent/Administration Form**

Name \_\_\_\_\_  
(Last) (First) (Middle Initial)

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender M F Marital Status \_\_\_\_\_ Race \_\_\_\_\_  
Month/Day/Year (optional)

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

	Yes	No
Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>
Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Has the person to be vaccinated ever had a serious reaction to influenza or pneumonoccal vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Has the person to be vaccinated ever had Guillain-Barré Syndrome (GBS)?	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE TURN PAGE OVER AND COMPLETE OTHER SIDE**

**HEALTH DEPARTMENT USE ONLY**

\_\_\_\_\_  
Medical Screener Signature

\_\_\_\_\_  
Date

Influenza Manufacturer <b>GSK</b>
LOT NUMBER
INJECTION SITE

Influenza Manufacturer <b>Sanofi</b>
LOT NUMBER
INJECTION SITE

Pneumonoccal Manufacturer <b>Merck</b>
LOT NUMBER
INJECTION SITE

\_\_\_\_\_  
Vaccinator Signature

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES**

The CCHD Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice of Privacy Practices is subject to change. A copy of our Notice, is available upon request. By signing this form, you acknowledge that the CCHD Notice of Privacy Practices was made available to you.

**CONSENT**

You must be at least 18 years of age to sign. If under age 18, a parent or guardian’s signature is required. I have read or had explained to me the 2010-11 Vaccine Information Statement for the 2010-11 Influenza vaccine and/ or 2010-11 Vaccine Information Statement for the 2010-11 Pneumococcol vaccine and understand the risks and benefits. Vaccine Information Statements (VIS Forms) have been made available to me and I understand the information about the vaccine(s).

**PAYMENT INFORMATION**

**Option 1: Pay the day of the clinic.** Cash or check payments may be made on the day of the clinic.

**Option 2: Bill Insurance. Clay County Health Department can bill the insurances listed below for the immunizations.** I request that payment of authorized third party (including Medicare) benefits be made to Clay County Health Department for services furnished by the Department. Submission of insurance information does not guarantee coverage. I understand that if the insurance company does not cover the vaccine(s), I will be responsible for payment.

Please indicate your method of payment  Option 1 – Cash or Check  
 Option 2 - complete the following:

- |  |                                       |                                   |
|--|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Advantra Freedom  | <input type="checkbox"/> CHIPs        | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Blue Cross        | <input type="checkbox"/> Freedom Blue | <input type="checkbox"/> PEIA     |
| <input type="checkbox"/> Carelink          | <input type="checkbox"/> Humana       | <input type="checkbox"/> UMWA     |
| <input type="checkbox"/> Carelink Medicaid | <input type="checkbox"/> Medicare     | <input type="checkbox"/> Wellcare |
| <input type="checkbox"/> Other _____       |                                       |                                   |

Policy Holder’s Name \_\_\_\_\_  
(Last) (First)

Patient Relationship to Policy Holder Self Spouse Child Other(describe) \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ Policy ID Number: \_\_\_\_\_ Group # (if any) \_\_\_\_\_

\_\_\_\_\_  
Patient/Patient Representative’s Signature Date

**Health Department Use Only – Patient Pay**

Amount Paid \_\_\_\_\_ Cash Check Check # \_\_\_\_\_

Receipt # \_\_\_\_\_ Receipt issued by \_\_\_\_\_