Influenza Screening form 2022

Today's Date: ________________

Client's Name__________________________ Date of Birth________________Age:_______

Mailing Address______________________________________ City______________________

State________ Zip Code___________ Phone (___)__________________

Parents______________________________ Mother's Maiden Name________________________

Is the individual Hispanic or Latino? YES NO Circle: Male Female

Race: White American Indian more than one race other/unknown

Please Circle One: Veteran Active Duty Family Member

<u>If you have insurance please call them to verify immunization coverage prior to completing this form – Thank You.</u> RCHD is not responsible to inform you of what your insurance will not cover. You will be responsible for any balance.

<u>Determining VFC</u>

Do you have health insurance that covers vaccines? Yes or No
What is the name of your insurance?______________________________
Name of the cardholder_______________________________________
Do you qualify for IHS (Indian Health Service) Yes or No
or other federally funded insurance?
Is your child enrolled in Healthy Montana Kids Plus (Medicaid) Yes or No

<u>Cost & Method of Payment</u>

******If your <u>child 0-18 yrs. of age,</u> does not have insurance or you qualify for IHS or your insurance does not cover vaccines, your child may be eligible for Vaccines for Children Program, please ask. ******

<u>Please photocopy front and back of insurance or Medicare card and bring it with you.</u>

Payment is required at the time of service and a charge sheet will be provided for you to submit to your insurance for reimbursement purposes.

Influenza (90686) $40
Flulaval
Fluarix
Fluzone
High Dose Influenza (90662) $80

PAYMENT-FOR OFFICE USE ONLY
Cash: ____________________
Check #: __________________
Credit:____________________
Employer responsible to pay:
____

I give permission for Richland County Health Department to enter my vaccine information into the electronic statewide immunization registry. This information will only be shared with health care providers as necessary.

Client Signature______________________________________Date_____________________________

For Nurses Only **<u>Influenza VIS form date: 8-6-2021</u>** **VFC** Left Deltoid
PRIVATE Right Thigh

Date:____________________________
Form Reviewed/Vaccinator Signature:____

Please fill out reverse side

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Screening Checklist for Contradictions to Inactivated Injectable Influenza Vaccination

For patients (both children and adults) to be vaccinated: The following questions will help us determine if the vaccinations may be given to you or your child today. If you answer "yes" to any question, it does not necessarily mean you or your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is client sick today?			
2. Does client have allergies to a vaccine component or to latex?			
3. Has client had a serious reaction to a vaccine in the past?			
4. Has client had brain or other nervous system problems?			
5. For Females: Is client pregnant?			
6. Are you a person ages 6 months to 64 years old with weakened immune systems or chronic illnesses such as heart, lung, kidney disease & including asthma?			
7. Is there anyone under the age of 6 months in your household?			
8. I feel I was able to receive this service because of the help I have received from the staff and volunteers?			

FORM COMPLETED BY____DATE________________________________

FORM REVIEWED BY____DATE_________________________________

immunization action coalition

Saint Paul, Minnesota.651-647-9009.www.immunize.org.www.vaccineinformation.org

immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

www.immunilll!.org/cats.d/p4066.pdf-Item #P4066 (9/1.7: