

Today's Date: _____ Last Name: _____

DICKINSON COUNTY PUBLIC HEALTH

2301 HWY 71 S • P. O. Box AB Spirit Lake, IA 51360

Phone: (712) 339-6050 Fax: (712) 339-6052

First Name:



SCREENING QUESTIONS - Please circle Y or N for Yes or No. Use the back for allergy and other information													
	#1 Self F			ember #2	Family M	Family Member #3		Family Member #4		Family Member #5		Family Member #6	
First and Last Name													
Date of Birth													
Relationship to above													
Primary Physician/Nurse Practitioner													
First time receiving the flu vaccine? *It is recommended that children 8 and under who have NEVER had flu vaccine or had only one dose, receive two dose in the same flu season.	Υ	N	Y	N	Υ	N	Υ	N	Υ	N	Υ	N	
Allergies to chicken eggs, egg products, thimerosal, latex or any component of the flu vaccine?	Υ	N	Υ	N	Υ	N	Υ	N	Υ	N	Υ	N	
Have you/your child ever had a severe allergic reaction to previous flu vaccine?	Υ	N	Υ	N	Υ	N	Υ	N	Υ	N	Υ	N	
Do you have a history of Guillain-Barre Syndrome (GBS)?	Υ	N	Υ	N	Υ	N	Υ	N	Υ	N	Υ	N	
Have you received any vaccines in the past 30 days? If yes, list vaccines and dates in the box.	Υ	N	Y	N	Y	N	Y	N	Y	N	Y	N	
Address:					P. O. Box:								
City:				St	ate:			Zip Code:					
Primary Phone:				Alter	nate Phon	e (Optior	nal):						

CONSENT

CONSENT - I have read or had explained to me the information in the Vaccine Information Statement about the 2019-2020 influenza vaccine (08/07/2015). I believe I understand the benefits and the risks of the influenza vaccine and ask that the vaccine be given to me and/or my child/children. I understand that these vaccines will be entered into the lowa Immunization Registry (IRIS). I attest I am the child's/children's parent/legal guardian and may provide consent for the immunizations. My signature on the back indicates my consent for me and/or my child/children to receive these vaccines.

CIAI RF	

FINANCIAL RESPONSIBILITY - All or part of the amount charged will be billed to my insurance carrier(s). Any amount the insurance companies pay will be applied to the amount due and any amount my carrier deems payable by the insured will be billed to me. I understand I will have 30 days from the date of the statement to send payment to the clinic. I understand that I am ultimately responsible for payment of the immunizations and/or the administration fees charged. All information provided is true and correct to the best of my knowledge. For Children 18 Years old and younger- If your insurance does not cover immunizations, vaccine will be provided through the Vaccine for Children (VFC) Program. A donation of \$15 to cover the cost of the administration would be appreciated.

Please Present Health Insurance Card / MEDICARE PART B Card / Medicaid - T-19 Card

MEDICARE ADVANTAGE PLAN HOLDERS - I understand that not all Medicare Advantage plans will cover flu vaccine. If NOT covered, I will receive a bill from the clinic. My initials in the box (to the right) indicate that I understand that I am ultimately responsible for payment and any administration fees for the flu vaccine. PLEASE INITIAL AND DATE BOX AT RIGHT noting that you understand

Patient/Guardian/DPOA Signature

Spouse Signature (If listed as a patient)

For Office Use Only * (Age 8 and under if required) * 2nd Dose required if child is 8 or younger and has NEVER had flu vaccine or has only had 1 dose of flu vaccine.

	Family Member Name	Age	Physician OR Nurse Practitioner	Nurse Initials	Dose & Route	Site		Flulaval Quad P-FREE Dose 1	Flulaval Quad P-FREE Dose 2*	Fluarix Quad P-Free Dose 1	Fluarix Quad P-Free Dose 2*	Fluzone HIGH DOSE
1.					I CAN TYPE	RD / RT	LD / LT					
2.					THIS IN	RD / RT	LD / LT					
3.						RD / RT	LD / LT					
4.						RD / RT	LD / LT					
5.						RD / RT	LD / LT					
6.						RD / RT	LD / LT					

	Family Member Name	Child Medicaid	No Health Insurance	AI/AN	UI	Not Eligible for VFC	Adult Medicaid	Medicare Part B	Medicare Advantage	Cash/Check Credit/Debit	Bill to Other
1.											
2.											
3.											
4.											
5.											
6.											