Location : ____________________

Receipt # ____________

Initials ____________

Rambo Memorial
HEALTH CENTER

Please PRINT: **2017-18 Influenza Vaccine Permit** **(Please fill out completely)**

Today's Date: ____________ Medicare Part B, Humana or Medigold #: ____________

Name: ______________________________
FIRST MIDDLE INITIAL LAST

STREET ADDRESS: ______________________________
(No P.O. Box)

City: ____________ State: ________ Zip: ________ **County**: ____________

Sex: ☐ M ☐ F Birthdate: ____________ AGE: ______ Phone#: ____________
MM — DD — YYYY

In County $5.00 ☐ Out of County $20.00 ☐ **(If child is under 3 years of age, please list age in months.)**

For VFC vaccine : Patient *is under age 19* [ ] yes ***AND*** **Patient has** [ ] **NO** INSURANCE or
[ ] Traditional Ohio Medicaid [ ] Molina [ ] Caresource [ ] Paramount [ ] Buckeye Health Plan [ ] United Health Care Plan

By signing this form, I agree to the following: I understand there is always a possibility of an adverse reaction to any vaccine or drug. I understand the benefits and risks of influenza vaccine. I have been offered a copy of the CDC Vaccine Information Sheet. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

Traditional Medicare Part B, Medigold and Humana Medicare Recipients: I understand the Influenza Vaccine is provided at no cost to me, and authorize the release of any medical or other information necessary to process the claim.

HIPAA: I have been offered the Agency's Notice of Privacy Practices and understand that my protected health information may be used by the Agency as described in the notice.

Please answer the following questions:

1. Are you allergic to eggs, mercury, latex, thimerosal, or gelatin? Yes ☐ ☐ No
2. Have you ever had a serious allergic reaction to a previous dose of flu vaccine? .... Yes ☐ ☐ No
3. Do you have a history of Guillain-Barre'?........................ Yes ☐ ☐ No
4. Do you NOW have a fever or are severely ill? .... Yes ☐ ☐ No
5. Are you pregnant or planning to get pregnant soon? .... Yes ☐ ☐ No

SIGNATURE : Patient or Parent/Guardian ______________________________

For Clinic Use Only

Date: ____________ Signature : ____________ **VIS** 8/7/2015 Given [ ]

Site Given: RA LA RT LT

Fluzone 0.25ml. 0.5ml. Flulaval 0.5ml. Fluarix PFS 0.5ml. Lot #: Exp: