Rambo Memorial Health Center

Location : _____

Receipt # _____

Initials_____

Please PRINT: **2020-2021 Influenza Vaccine Permit** **(Please fill out completely)**

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

Name:_____
FIRST MIDDLE INITIAL LAST

STREET ADDRESS: (NO PO 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.

SIGN HERE

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: _____ GIVEN BY: Signature: _____ **VIS** 8/15/2019 Given [ ]

Site Given: RA LA RT LT Fluzone HD 0.7 ml._____

Fluzone PFS 0.5ml. _____ **Flulaval PFS 0.5ml.** Lot #: P7HK7 Exp: 06-30-2021