



Location : _____

Receipt # _____

Initials _____

Please PRINT: 2021-2022 Influenza Vaccine Permit (Please fill out completely)

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

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, & 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 |
| 6. Have you had a Covid-19 vaccine in the last 30 days?..... | Yes | No |

SIGNATURE : _____ (Patient or Parent/Guardian)

For Clinic Use Only