

**Pocahontas County Health Department
 21 3rd Avenue NE
 Pocahontas, Iowa 50574
 Phone: 712-335-4142
 Fax: 712-335-3581**

Flu Vaccination Form (PLEASE PRINT)

Last Name	First Name M / F	MI	DOB MM/DD/YYYY
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Age	Gender	Phone	Family Physician
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Street Address	City	State	Zip
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Are you sick today?	Yes	No
Do you have an allergy to a component of the vaccine?	Yes	No
Have you ever had a serious reaction to the influenza vaccine in the past?	Yes	No
Have you ever had Guillain-Barre syndrome?	Yes	No

I have been offered a copy of the Notice of Privacy Practices, Policy and Procedure. My signature authorizes Pocahontas County Health Department to bill my insurance company or Medicare depending on eligibility.

I have been given and have read the information in the 'Vaccine Information Statement' (08/06/21) for the Inactivated Influenza Vaccine. I understand the benefits and risks of the vaccine and also understand that I have the choice to decline the vaccine.

Individual's Financial Responsibility: I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service. _____ (please initial)

Client or parent/guardian signature _____ **Date** _____

PLEASE CHECK THE GROUP YOU QUALIFY FOR:

TYPE OF FLU VACCINE AVAILABLE:

_____ Private Pay

Fluzone High Dose quad – 65 & older - \$65

_____ Medicare Part B (Copy of Card)

Fluarix quad – 6 months & older - \$30

_____ Wellmark BC/BS (Copy of Card)

FluLaval quad - VFC

_____ Medicaid-VFC (Copy of Card)

*****OFFICE USE ONLY*****

Date	Vaccine	Site	Lot #	Administered by:
	Fluzone High Dose	RD/LD I.M.		
	Fluarix	RD/LD I.M.		
	FluLaval	RD/LD I.M.		