Influenza Immunization Questionnaire

PLEASE PRINT the Following Information

Name ____________________ **Phone** (____)____________

Street Address ____________________ **City/State/Zip Code** ____________________

Birth Date ____/____/____ (Month Day Year) **Age Today** ______ **Gender** ☐ F ☐ M **History of Chicken Pox** ☐ Yes ☐ No

Parent/Guardian Email ____________________ **Cash Amount Sent with Child:** $________

Race:
- ☐ Caucasian
- ☐ Black/African American
- ☐ Asian
- ☐ Native American
- ☐ Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino

Insurance Status:
- ☐ Private Insurance ***Turn over for Private Insurance Information*** →
- ☐ Insured, but vaccines are not covered
- ☐ Uninsured / No insurance
- ☐ Medicaid # ____________________
- ☐ Nevada Check-up #____________________

ATTENTION: It is advised to wait approximately 15 minutes after receiving a vaccination before driving.

Please answer the following questions about **THE PERSON** to be vaccinated.

1. Sick today? ☐ Yes ☐ No
2. Allergic to eggs, food, medication, vaccine component or latex ? ☐ Yes ☐ No
   If yes, state allergy ____________________
3. Had a serious reaction to or fainted with any previous immunization? ☐ Yes ☐ No
4. Had Guillain-Barré syndrome in the past? ☐ Yes ☐ No
5. Had a seizure or other nervous system problem? ☐ Yes ☐ No
6. Have cancer, AIDS or other immune system problems? ☐ Yes ☐ No
7. Taken any cortisone, prednisone or any steroids, anti-cancer drugs, or radiation in the last 3 months? ☐ Yes ☐ No
8. Received antiviral drugs in the last 3 months? ☐ Yes ☐ No
9. Received any other immunizations, including influenza, in the last month? ☐ Yes ☐ No
   If yes, type of vaccine ____________ date: ________
10. Received a transfusion of blood or blood product, or been given immune (gamma) globulin in the last year? ☐ Yes ☐ No
11. Have long-term health problems with diabetes, heart disease, lung disease, asthma, wheezing, kidney disease, anemia or other blood disorders? ☐ Yes ☐ No
12. Pregnant or plan to become pregnant in the next month? ☐ Yes ☐ No
13. Been vaccinated against influenza in the past? ☐ Yes ☐ No
14. Vaccine to be received *(please select only one):* ☐ **Either Shot or Nasal** ☐ **Shot** ☐ **Nasal**

- I have received and understand the vaccine information sheet(s) for the immunization(s) to be administered.
- I authorize CCHHS to enter this information into the Nevada Immunization Registry, unless otherwise specified.
- I understand the CCHHS Notice of Privacy is available upon request & at: http://gethealthycarsoncity.org/school-located-vaccination-program/

Client/Parent/Guardian Signature ____________________ Date ____/____/____

Client/Parent/Guardian **Print Name** ____________________

(Parent signature required if under 18 years old)

PLEASE DO NOT WRITE BELOW THIS LINE

	Manufacturer		Lot #	Exp.					
Fluarix - Quad (90686) V04.81 VIS 7/2013	GSK	☐ VFC	**G7BL9 (VFC)**	6/30/2014	RD	LD			IM
		☐ Private							
Flu Mist (90660) V04.81 VIS 7/2013	Med-Immune	☐ VFC	**BH2090 (VFC)**	12/2/2013	Nasal				
		☐ Private							

Administered by: ____________________ (First Initial, Last Name, Credentials) Date: ____/____/____ Clinic Location: ____________________

(Write Legibly)

Immunization Payment Information

Immunization Fee: $20

Child's School: ____________________ Teacher's Name ________________________ Grade:_____

To Have CCHHS Bill Your Health Insurance:

We Accept:

- Cigna
- Hometown Health
- PEBP
- Aetna
- Coventry Health Care
- Humana
- St. Mary's Health Plans
- Anthem Blue Cross/Blue Shield
- Gov't Employee Health Association (GEHA)
- Nevada Preferred Provider
- Universal Health

If you have one of the above health insurance, please provide the following information for the POLICY HOLDER or attach a copy (front and back) of the policy holder's insurance card. *Please* PRINT

Insurance Company Name: ____

Customer Service Phone # (on insurance card): ________________________________

Insurance ID #: ___________________________ Group #: ___________________________

Policy Holder Name: ____
Last First M.I.

S.S # ______ -_______ -______ Birth Date _____/_____/_____ Gender ☐ M ☐ F

Mailing Address: ____
Street Apt # City State Zip Code

Daytime Phone #: (_____)________________ Relationship to Patient: ____________________

I authorize CCHHS to bill my insurance and release information necessary to process this claim. I understand that I am responsible for knowing covered services and knowing if the family's deductible has been met. I understand that I may be responsible for a payment to CCHHS. I hereby authorize payment directly to CCHHS.

Signature ____ Date _____/_____/______

If your child has health insurance from a private insurance company not listed above, please pay with credit card, check or cash for the amount of the immunization . For informational purposes, what company is your child's health insurance through? ________________________________

To Pay by Credit Card: Immunization Fee Amount: $____________

☐ VISA or MasterCard #: ________________________________

Exp. Date: _______/_______/________ CVV2 Code: ________ (3 digit number on back of credit card)

Cardholder Name: ________________________________

Cardholder Signature: ________________________________

To Pay by Check: Immunization Fee: $____________

☐ Make check payable to: **Carson City Health and Human Services**

For Office Use Only

Date ____/____/____ Amount $ _______ ☐ Check ☐ Cash ☐ Credit Initials _______