## Southwest Utah Public Health Department - Flu Vaccine Registration Form

| Last Name | First Name | Middle Name | Female Male | Date of Birth | Age |
|---|---|---|---|---|---|
| | | | | | |

| Mother's Maiden Name | Head of Household Name (if client is a minor) |
|---|---|
| | |

| Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Home Phone | Cell Phone | Email |
|---|---|---|
| | | |

| Hispanic/Latino? Yes No | Race: White Asian Black Pacific Islander Native American/Alaskan Native Other _____ |
|---|---|

| How did you hear about this event? |
|---|
| |

## Please answer the following questions:

| | | |
|---|---|---|
| * Is the person to be vaccinated sick today? | Yes | No |
| * Does the person to be vaccinated have an allergy to eggs, gelatin, thimerosal or other vaccine component? | Yes | No |
| * Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? | Yes | No |
| * Has the person to be vaccinated ever had Guillain-Barré syndrome? | Yes | No |
| * Is the person to be vaccinated pregnant? | Yes | No |

### CONSENT FOR TREATMENT AND PRIVACY NOTICE

I certify that the information I have provided is true and accurate. I have been given a copy and have read, or have had explained to me, the information contained in the Vaccine Information Statement (VIS) about the disease. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine(s) indicated be given to the person named above for whom I am authorized to make this request. I agree that this information may be shared with schools, daycare centers, health care providers and others when deemed medically necessary.

I hereby release Southwest Utah Public Health Department (SWUPHD), and its employees, from all claims arising from such immunizations. I authorize Medicaid or insurance benefits to be paid to the SWUPHD or its authorized agent and for the SWUPHD or its authorized agent to release information to Medicaid or insurance companies as necessary for claims. I understand that I may be liable for all or a portion of the bill.

We are required to inform you of our privacy practices for the information we collect and keep about you. I have been given a copy of the Health Department's Notice of Privacy Practices and have had an opportunity to ask questions about how my information may be used.

**X**_____ **Date**_____

Signature of patient or parent/legal guardian

| FOR OFFICE USE ONLY | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **VFC:** | Medicaid | CHIP | No insurance | Am Ind/Ak Nat | **Medicaid:** | State | Molina | SHCC | HC | HU | | |
| **Private:** | Aetna | Cigna | DMBA | Educators Mutual | Healthy Premier | MotivHealth | PEHP | SelectHealth | Tall Tree | United Health | Medicare | Medicare HMO |
| **Self Pay:** | Amt _____ | CC | Cash | Chk # _____ | | | | | | | | |

| Date | Vaccine | Lot# | Dose | Site | Nurse |
|---|---|---|---|---|---|
| | Flu – inject. | | 0.5 mL<br>0.7 mL | LD RD<br>LVL RVL | |