

Macomb County Health Department Seasonal Influenza Vaccine Program Date: _____

Birthdate: _____ Social Security #: _____ Medicare #: _____

Legal Name: _____

Street Address: _____ (Last Name) _____ (First Name) _____ (Middle Name) _____
City: _____ State: _____ Zip: _____ County: _____

Telephone # _____ Sex (Circle One): Male Female

Are you enrolled in any of the following? _____ Medicare Part B _____ Medicaid _____ No Medical Insurance
_____ Commercial Insurance that **does** cover immunizations _____ Commercial Insurance that **does not** cover immunizations

THIS SECTION TO BE COMPLETED ONLY BY VALID MEDICARE PART B CARD HOLDERS ONLY:
I authorize any holder of medical information about me to release to Medicare or their Intermediaries or carriers, information needed for this claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment below.
Signature X _____ Macomb County Health Department Accepts Assignment

Medical Screening Questionnaire and Consent for Vaccination

Please answer the following questions about you or the person to be vaccinated:

YES NO

- Have you ever had a serious reaction to a vaccine?
- Are you allergic to eggs, Thimerosal, gelatin, or any antibiotics?
- Have you received an influenza vaccination before?
- Have you ever had Guillain-Barré Syndrome (GBS)?
- Do you have any long-term health problem such as heart or lung disease, kidney disease or metabolic disease (diabetes)?
- Do you have severe thrombocytopenia (low platelet count) or a bleeding disorder?
- Are you currently ill or running a fever?
- Do you have asthma or have you had a recent episode of wheezing in the past 12 months?
- Are you or do you think you may be pregnant?
- Have you received any vaccine within the past 30 days?
- Do you have cancer, leukemia, lymphoma, or any immune deficiency disease (inability to fight infection) or are you currently receiving chemotherapy, radiation therapy or steroid therapy (prednisone or cortisone)?
- Do you have close contact with anyone who has a severely weakened immune system (for example, an individual who has had a bone marrow transplant and is currently in a hospital isolation room)?
- Are you a current smoker?

(Section to be used in Community Outreach Settings)
Medical Screener: _____ (initials)
 Denied Reason: _____

(Include MCHD Staff 3 digit ID)

I have read or have had explained to me, the information contained in the Vaccine Information Statement(s) regarding the vaccine(s) to be administered today. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the specific vaccine(s). I ask that the vaccine(s) be given to me, or to the person for whom I am authorized to make this request. I also authorize the Macomb County Health Department to release my immunization record information, or the immunization record information of the person for whom I am authorized to make this request to other health care provider(s) as needed.

Macomb County Health Department Notice of Health Information Practices

I have received a copy of Macomb County Health Department's Notice of Health Information Practices. I understand that my acknowledgement of the Notice is evidenced by my signature on this document. The Department is required to abide by the terms of this privacy notice. The Department may change the terms of its notice at any time. The new notice will be effective for all protected health information that it maintains at that time. Upon my request, the Department will provide me with the revised notice of privacy practices.

X _____
SIGNATURE of Client/Legal Guardian

PRINT NAME of Legal Guardian (if applicable)

THIS SIDE OF FORM TO BE COMPLETED BY MACOMB COUNTY HEALTH DEPT STAFF ONLY

MCHD OFFICE STAFF USE ONLY:

Date of Service: _____

_____ Medicare _____ Self Pay MC (01) _____ Client ID _____
 _____ Medicaid _____ No Pay (Wavied/250) WRN (02) _____ SCS (03) _____ (91/92/93) Facility Zip Code _____
 Does client have HAP Insurance? **YES** **NO** (MCHD cannot accept HAP MEDICARE/becomes self pay client)

Nurse Staff ID _____

Nurse Confirmation of Client's Birthdate: _____

<u>Vaccine</u>	<u>Mfg/Lot#</u>	<u>Route</u>	<u>Site</u>	<u>VIS Date</u>	<u>VIS Given</u>
Flu	_____	IM	RT LT RD LD	07/26/2011	<input type="checkbox"/>
LAIV	_____	IN (Intranasal)	IN	07/26/2011	<input type="checkbox"/>
(Circle One)					
PP23/P23V	_____	SC IM	RA LA RL LL RT LT RD LD	10/06/2009	<input type="checkbox"/>
Td/TdC/Tdp/TdpC	_____	IM	RT LT RD LD	11/18/2008	<input type="checkbox"/>
(Circle One)					

Progress Notes: _____

Please copy Medicare Part B card or MEDICAID card/commercial insurance cards and driver's license below.
 (If Medicare Part A only, do not copy Medicare card; client becomes self pay client)