Southwest Utah Public Health Department - Flu Vaccine Registration Form

Patient Last Name	First Name	Middle	Date of Birth (mm/dd/yy)	Age

Race			Ethnicity	Language	Gender
☐ White	☐ Black	☐ Asian	☐ Hispanic		☐ Male
☐ American Indian	☐ Alaskan Native	☐ Pacific Islander	☐ Non Hispanic		☐ Female

Address	Unit/Apt	City	State	Zip code

Primary Phone #		Email
	☐ Cell ☐ Home ☐ Work	

Primary Health Insurance	Policy #	Policy Holder (Exact name listed on card)

Policy Holder Date of Birth (mm/dd/yy)	Relationship to Patient	Address of Policy Holder

How did you hear about this event?

Sign Here

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 important Vaccine Information Statements. I have had a chance to ask questions, which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines and request that the vaccines 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, day care centers, health care providers, others when deemed medically necessary, and the Utah State Immunization Registry.

I HEREBY RELEASE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND ITS EMPLOYEES, FROM ALL CLAIMS ARISING FROM SUCH IMMUNIZATIONS.
I UNDERSTAND THE BILLING OF MEDICAL INSURANCE DOES NOT GUARANTEE PAYMENT AND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE.

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 Signature** ______________________________ Print Name _______________________________Date_____________

Relationship to Patient: ☐ **Self** (Must be 18 or older) ☐ **Parent** ☐ **Legal Guardian** ☐ **Other** _____________

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

FOR OFFICE USE ONLY	
VFC: Medicaid CHIP No insurance Am Ind/Ak Nat	Medicaid: State (FFS) Molina SHCC HC HU
PRIVATE	Aetna Cigna DMBA Educators Mutual Healthy Premier MotivHealth PEHP SelectHealth Tall Tree United Health Medicare Medicare HMO
PAYMENT: Amount Paid $________ Payment Type: CC Cash Chk # __________ Clerk Initials:_____________	

Date	Vaccine	Lot#	Dose	Site	Nurse
	Flu – inject.		0.5 mL 0.7 mL	LD RD LVL RVL	