# Southwest Utah Public Health Department - Flu Vaccine Registration Form

| Patient Last Name | First Name | Middle | Date of Birth (mm/dd/yy) | Age | Gender ☐ Male ☐ Female |
|---|---|---|---|---|---|
| | | | | | |

| Race | Ethnicity | Emergency Contact (name, phone number, relationship) |
|---|---|---|
| ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Pacific Islander | ☐ Hispanic ☐ Non-Hispanic | |

| Address | Unit/Apt | City | State | Zip code |
|---|---|---|---|---|
| | | | | |

| Primary Phone # | ☐ Cell ☐ Home ☐ Work | Email |
|---|---|---|
| | | |

| Primary Health Insurance | Policy ID # | 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?**

| 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? | | |
| Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot? | | |

**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 offered 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** _____

**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 Molina Marketplace 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 | LD RD LVL RVL | |

VIS Date 01/31/2025 Rev 8/2025 smc