## Influenza Screening form 2023

Today's Date: ___________________

Client's Name_______________________________ Date of Birth_________________ Age___________

Mailing Address__________________________________________ City___________________________

State___________ Zip Code______________ Phone (_____)___________________________

Parents_______________________________________ Mother's Maiden Name_______________________

Is the individual Hispanic or Latino? YES NO Circle: Male Female

Race: White American Indian more than one race other/unknown

Please Circle One: Veteran Active Duty Family Member

**<u>If you have insurance, please call them to verify immunization coverage prior to completing this form – Thank You.</u>**

RCHD is not responsible for informing you of what your insurance will cover. You will be responsible for any balance.

***<u>Cost & Method of Payment</u>***

****If your child is 0-18 yrs. of age, does not have insurance or you qualify for IHS or your insurance does not cover vaccines, your child may be eligible for Vaccines for Children Program, please ask. ****

Do you have health insurance that covers vaccines? Yes or No

What is the name of your insurance? ___________________________________

Name of the cardholder ______________________________________________

Do you qualify for IHS (Indian Health Service) Yes or No

Is your child enrolled in Health Montana Kids Plus (Medicaid) Yes or No

**If you do not have insurance, payment is required at the time of service.**

### Screening Checklist for Contradictions to Inactivated Injectable Influenza Vaccination

For patients (both children and adults) to be vaccinated: The following questions will help us determine if the vaccinations may be given to you or your child today. If you answer "yes" to any question, it does not necessarily mean you or your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

| | Yes | No | Don't Know |
|---|---|---|---|
| 1. Is client sick today? | | | |
| 2. Does client have allergies to a vaccine component or to latex? | | | |
| 3. Has client had a serious reaction to a vaccine in the past? | | | |
| 4. Has client had brain or other nervous system problems? | | | |
| 5. For Females: Is client pregnant? | | | |
| 6. Are you a person ages 6 months to 64 years old with weakened immune systems or chronic illnesses such as heart, lung, kidney disease & including asthma? | | | |
| 7. Is there anyone under the age of 6 months in your household? | | | |
| 8. This event gave me better access to services? | | | |

I give permission for Richland County Health Department to enter my vaccine information into the electronic statewide immunization registry. This information will only be shared with health care providers as necessary.

**Client Signature**__________________________________________________Date___________________

**How did you hear about the flu clinic? (Please circle all that apply)**

Radio Facebook Flyer News Story News Ad Word of mouth

## FOR OFFICE USE ONLY

**Influenza (90686)** $45
- Flulaval
- Fluarix
- Fluzone

**High Dose Influenza (90662)** $85
- 65+ years old - **no exceptions**

**Payment:**

**Cash:________________________**

**Check #:______________________**

**Credit:________________________**

**Employer responsible to pay (pre-approved):**

**Richland County**

**City of Sidney**

**MDU**

**Stockman Bank**

**_______________________**

**For Nurses Only** **Influenza VIS form date: 8-6-2021**

| **VFC** | Left | Deltoid |
|---|---|---|
| **Private** | Right | Thigh |

Date: ____________________________

Form Reviewed/Vaccinator Signature: ______________________________________