Influenza Screening form 2021

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

Are you Military? NO YES: Please Circle One: Veteran Active Duty Family Member

If you have insurance please call them to verify immunization coverage prior to completing this form – Thank You. RCHD is not responsible to inform you of what your insurance will not cover. You will be responsible for any balance.

Determining VFC

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
or other federally funded insurance?
Is your child enrolled in Healthy Montana Kids Plus (Medicaid) Yes or No

Cost & Method of Payment

******If your child 0-18 yrs. of age, does not have insurance, qualifies for IHS, or your insurance does not cover vaccines, the cost is $21.32 per immunization. ******

Please photocopy front and back of insurance or Medicare card and bring it with you.

Payment is required at the time of service and a charge sheet will be provided for you to submit to your insurance for reimbursement purposes.

Influenza (90686) $40
Flulaval
Fluarix
Fluzone
High Dose Influenza (90662) $80

PAYMENT-FOR OFFICE USE ONLY
Cash: _____
Check #: _____
Credit:_____
Employer responsible to pay:
_____

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_____

For Nurses Only **Influenza VIS form date: 8-6-2021** **VFC** Left Deltoid
PRIVATE Right Thigh

Date:_____
Form Reviewed/Vaccinator Signature:_____

Please fill out reverse side

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?			

FORM COMPLETED BY_____DATE_____

FORM REVIEWED BY_____DATE_____

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota.651-647-9009.www.immunize.org.www.vaccineinformation.org

www.immunilll!.org/cats.d/p4066.pdf-Item #P4066 (9/1.7: