CLARKE COUNTY PUBLIC HEALTH

*************PLEASE COMPLETE*************

PATIENT INFORMATION ***PLEASE PRINT***

Full Name		Date of birth	
Address		Gender	MALE FEMALE
City/ State / Zipcode			
Phone Number			

CONSENT FOR VACCINATION ***PLEASE READ BEFORE SIGNING AND DATING***

I have received or have been offered a copy of the current Influenza Vaccine Information Sheet and screening form prior to vaccination. I have had a chance to read and ask questions. I understand all the risks and benefits involved.
I understand that if any effects are experienced, it will be my responsibility to follow up with a physician at my expense. ***Mild reaction for injection*** include soreness, redness, or/and swelling where the shot was given, hoarseness, sore, red or itchy eyes, cough, fever, aches, headaches, itching, fatigue.

I GIVE CONSENT to Clarke County Public Health to administer the vaccine. I expressly release from any liability the above name organization and individual giving vaccine(s). I, for myself, my heirs, executors, and assigns hereby agree to release the sire provider and employees from any and all claims arising out of, in connection with, or in any way related to my receipt of vaccine.
I hereby authorize and request my insurance company to pay benefits which may be due for covered immunization administered by Clarke County Public Health Employer ID 42-6005082 Non Profits status. I understand this authorization applies to those eligible charges submitted in connection with immunizations administered only by and though the above provider. I also understand the benefit check and a copy of the benefits summary form will be mailed directly to the provider. If coverage is denied by my insurance plan, I understand that I will be responsible to reimburse Clarke County Public Health for all immunization administered at the current fee. All vaccine information will be entered into Iowa's Immunization Registry Information System, (IRIS).

(Print) Person receiving vaccine or Name of Parent/Guardian	Signature Person receiving vaccine or Name of Parent/guardian	Date

METHOD OF PAYMENT ***FACILITY USE ONLY**

	NO insurance or insurance does not cover vaccines		
	Medicaid (ADULT TITLE 19)	provider and # :	
	Medicare	Medicare # :	
	$40 reg/ 60 HD Check	Makes checks payable to Clarke County Public Health	
	$40 reg/ 60 HD to Credit/ Debit	Card Holder's Name:	Last 4 numbers:
	Bill BlueCross BlueShield	ID #: ____________________	

NOTE: I understand that if my insurance does not cover the cost of vaccines I will be held responsible for the full payment of vaccine

FOR STAFF USE ONLY

__ PRIVATE __ HIGH DOSE __ VFC		__ IM Injection 0.25 cc 0.5 cc Site: Right Deltoid Left Deltoid Right Thigh Left Thigh	Administered by: __ H. Buckingham LPN __ H. Rash RN __