LoupBasin

# LOUP BASIN PUBLIC HEALTH DEPARTMENT IMMUNIZATION CONSENT

934 I Street Burwell, NE 68823
308.346.5795

## CLIENT INFORMATION

| LAST NAME | FIRST NAME | MI | MAIDEN NAME (IF APPLICABLE) |
|---|---|---|---|
| | | | |

| DATE OF BIRTH | AGE | SEX M F | MOTHER'S MAIDEN NAME (FIRST AND LAST) | PHONE ( ) |
|---|---|---|---|---|
| | | | | |

| YOUR STREET ADDRESS | CITY | STATE | ZIP | PHYSICIAN |
|---|---|---|---|---|
| | | | | |

EMAIL ADDRESS (FOR ACCESS TO PATIENT PORTAL, APPT REMINDERS, ETC)

## INSURANCE INFORMATION

RELATIONSHIP OF CLIENT TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER_____

| SUBSCRIBER NAME (IF DIFFERENT THAN ABOVE) | SUBSCRIBER DATE OF BIRTH (REQUIRED) | SOCIAL SECURITY # | INSURANCE PROVIDER |
|---|---|---|---|
| | | | ☐ MEDICA<br>☐ BLUE CROSS BLUE SHIELD (MUST HAVE PHOTO/COPY OF CARD)<br>☐ MEDICAID *UHC NTC WELLCARE*<br>☐ AETNA<br>☐ MEDICARE (SS# REQUIRED)<br>☐ OTHER: |

| PHYSICAL ADDRESS (IF DIFFERENT THAN ABOVE) | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

PHOTO OF CARD (FRONT & BACK)
☐ DRCHRONO ☐ NEAT ☐ PHOTO COPY ATTACHED ☐ STAFF DEVICE (DEVICE #_____)

## SCREENING QUESTIONNAIRE

| THE QUESTIONS BELOW MUST BE ANSWERED PRIOR TO RECEIVING ANY VACCINATION. | YES | NO | DON'T KNOW |
|---|---|---|---|
| ARE YOU SICK TODAY? | | | |
| DO YOU HAVE ALLERGIES TO MEDICATIONS, FOOD (PARTICULARLY EGGS), A VACCINE COMPONENT OR LATEX? | | | |
| HAVE YOU EVER HAD A SERIOUS REACTION AFTER RECEIVING A VACCINATION? | | | |
| HAVE YOU HAD A SEIZURE, BRAIN/NERVOUS SYSTEM DISORDER OR GUILLAIN-BARRE? | | | |

**I GIVE CONSENT** to the **Loup Basin Public Health Department** and its staff to vaccinate the person listed on this form. I have read or had explained to me the Vaccine Information Statement and understand the risks and benefits. I hereby grant permission to Loup Basin Public Health Department to release any pertinent information to the above insurance company upon request and any physicians to whom I might be referred. I understand that I am financially responsible for charges not paid by my insurance company. If your insurance does not pay in full, you will be responsible for the remaining balance.*

_____ / / _____

**Authorized Signature** (*client, if 18 or older, or parent/legal guardian*) Today's Date: *(month/day/year)*

## FOR ADMINISTRATIVE USE ONLY

| VACCINE | FORM | AGE | CPT | ICD-10 | MAN/LOT/EXP | SITE | NURSE/DATE |
|---|---|---|---|---|---|---|---|
| ADMIN FEE | | | PRIVATE 90471 (1) 90472 (2+) | | MEDICARE G0008 | | |
| FLUZONE QUAD (SANOFI) | PREFILLED 0.25ML | 6-35 MO | 90685 | Z23 | | LA RA LL RL | |
| | PREFILLED | 3+ | 90686 | Z23 | | LA RA | |
| | HIGH-DOSE PREFILLED | 65+ | 90662 | Z23 | | LA RA | |
| FLUARIX QUAD (GSK) | PREFILLED | 3+ | 90686 | Z23 | | LA RA | |
| FLULAVAL QUAD (GSK) | MD VIAL | 3+ | 90688 | Z23 | | LA RA | |

DrChrono___/___ ____ NESIIS___/___ ____ Roster___/___ ____ Billed___/___ ____ Paid Cash/Donation____

(INACTIVATE)