HARVEY COUNTY HEALTH DEPARTMENT **Influenza Registration Form**

CLIENT INFORMATION: Legal Last: ____________________ Legal First: __________________ MI: _____

Birth Date: ______________________ SS#: ___________________________

Address: _________________________ City: __________________State:______ Zip Code:____________

Telephone: H (___)_________________ Cell (___)__________________ Work (___)___________________

School: ______________________ E-Mail, if over age 18: ____

==

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Widowed

Race: ☐White ☐ Asian ☐Black/African Am. ☐Am. Indian ☐Native Hawaiian/Pacific Islander ☐ Other

Ethnicity: ☐Hispanic ☐Non-Hispanic

==

PARENT/GUARDIAN INFORMATION (if client is under 18):

Last: ___________________________ First:____________________ MI:_____ Birth Date: _____________

Address: _________________________ City: ___________________State:______ Zip Code:__________

Telephone: H (___)_________________ Cell (___)_________________ Work (___)___________________

SS#________________________________ E-Mail:____

==

Payment or arrangements must be made before the vaccination will be given. How do you plan to pay?

If not filing insurance, please contact us at 316-283-1637 to discuss payment.

☐ I will pay full fee today. Cash or check. Make check out to the Harvey Co Health Dept.

☐ I wish to apply for a reduced fee. My family's **gross** income is ____________ per ________. (Please use your most current IRS Form 1040 Adjusted Gross Income if you filed taxes.) Number in household: __________.

☐ Bill private health insurance plan. Insurance card/information must be presented prior to or at time of service.
Policyholder's Name: __________________________ Policyholder's DOB: ___________________
Insurance Name: ______________________________ Member ID:_________________________

☐ Bill KanCare and/or Medicaid. Insurance card/information must be presented prior to or at time of service.
Child's Name as it appears on card: ___________________ Insurance Name:___________________
Insurance ID#: ________________________

==

Please read and check each box that applies before signing.

☐ I give consent for the person named above to receive the requested vaccination.

☐ I authorize immunizations for the person named above be sent to his/her school upon request.

☐ I request a copy of the Vaccination Information Statement be presented at time of service.

☐ I request a copy of the Health Department's Notice of Privacy Practices to be presented at time of service.

☐ I request payment of insurance benefits to the Harvey County Health Dept.

☐ I authorize the release of only the medical or billing information necessary to process claims for insurance providers including Medicare or Medicaid.

☐ I agree to be fully responsible for any co-pay, deductible or non-covered services.

____ ________________ ______________

Signature of Client or Responsible Party Relationship to Client Date

SEE BACK SIDE

HarveyCounty

For the client to receive any vaccine, all questions must be answered.

1. Does the client have any known allergies? YES NO

   If so, please list:______________________________________

2. Has the person to be vaccinated ever had a reaction to vaccinations (shots) before? YES NO

   If so, please describe:__________________________________

3. Has the client received any vaccine within 30 days before today? YES NO

4. Has the client ever received an influenza (Flu) vaccine? YES NO

5. Has the client ever had a reaction to an influenza (Flu) vaccination? YES NO

   If so, please describe:__________________________________

6. Has the client ever had Guillian-Barre syndrome (a form of paralysis)? YES NO

7. Does the client have asthma, recurrent wheezing, or active wheezing? YES NO

8. Is the person to be vaccinated currently sick or experiencing a high fever? YES NO

9. Does the client have any of the following:
   a. Kidney Disease? YES NO
   b. Heart Disease? YES NO
   c. Blood Disorder? YES NO
   d. Metabolic diseases (e.g. diabetes)? YES NO
   e. Any disease that lowers the body's resistance to infection? YES NO

10. Is the client taking steroids, arthritis medication, chemotherapy or recently completed a course of steroids? YES NO

11. Has the person to be vaccinated had a seizure, convulsions or other neurological problem? YES NO

12. Will the client have close contact with anyone who has a weakened immune system and requires care in a protective environment? YES NO

13. Is the client pregnant, nursing, or thinking of becoming pregnant within the next three months? YES NO