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| --- |
| C:\Users\rnorris\Pictures\Public_Health_Logo_2_Color.jpgLocation Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

Cash \_\_\_\_\_\_\_\_\_\_\_\_\_ Check # \_\_\_\_\_\_\_\_\_\_\_\_

Amt. \_\_\_\_\_\_\_\_\_\_\_\_ Insurance \_\_\_\_\_\_\_\_\_\_\_\_

VFC \_\_\_\_\_\_ Vaxcare\_\_\_\_\_ 317 \_\_\_\_\_\_

**WAYNE COUNTY HEALTH DEPARTMENT**

 **Nicholas Cascarelli, Ed.D**. *Health Commissioner* **Eric A. Smith, MD** *Medical Director*

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: □M □F

Race: □White □African-American □Asian □Multi-racial □Other Ethnicity: Hispanic/Latino: □ Yes □ No

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_

Primary Phone: (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_ Can we leave a message: Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

**Insurance Information:**

**In order to file insurance claims, complete the information below and show your insurance card.**

**Insurance Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Effective Date of Insurance? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance Subscriber \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |
| --- |
| **Screening Questions for vaccines** (**Circle Yes or No for each question) Explain “Yes” answers on back of page.** |
| Are you sick today? | **YES** | **NO** |
| Do you have any allergies or have you had any serious or life threatening reactions (anaphylaxis, difficulty breathing, etc.) to any foods, medications, or vaccines? (i.e.: eggs, gelatin, latex, etc.) | **YES** | **NO** |
| Do you have a history of seizures, Guillain-Barre Syndrome, or any other neurological conditions? | **YES** | **NO** |
| Have you ever felt dizzy or faint before, during, or after a shot? | **YES** | **NO** |
| Do you feel anxious or nervous about getting a shot today? | **YES** | **NO** |
| Would you like a copy of the Wayne County Health Department Privacy Policy? | **YES** | **NO** |

I hereby give my consent to the Wayne County Health Department to administer all requested vaccines. I understand the risks and benefits associated with the vaccine(s) being administered and have received, read and/or had explained to me the CDC’s Vaccine Information Statement (VIS) on the vaccine(s) I have elected to receive. I have had the opportunity to ask questions that were answered to my satisfaction. As with all medical treatment, there is no guarantee that I will not experience an adverse reaction from the vaccine. I understand that the information contained on this form may be shared with the state immunization registries and will remain confidential and will not be released except as permitted or required by law. I acknowledge that I have been offered a copy of the Notice of Privacy Practices. Furthermore, I agree to remain near the vaccination location for approximately 10-15 minutes after administration for observation by the administering Healthcare Provider.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR HEALTH DEPARTMENT USE ONLY**

\_\_\_\_\_\_ I have reviewed all immunization history to determine which vaccines are indicated for the client.

\_\_\_\_\_\_ I have reviewed the screening questionnaire and no contraindications have been found for the vaccines being administered.

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| [ ]  Trivalent Flu | [ ]  Left Deltoid [ ]  Right Deltoid | Lot# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  High Dose Trivalent Flu | [ ]  Left Deltoid [ ]  Right Deltoid | Lot# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Pfizer Comirnaty 24-25 | [ ]  Left Deltoid [ ]  Right Deltoid | Lot# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Nurse Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_