Putnam County Health Department

11878 Winfield Road - PO Box 892
Winfield WV 25213
(304) 757-2541

Seasonal Influenza/Pneumococcal Vaccination Consent/Administration Form

Name _____ _____ _____
(Last) **(First)** **(Middle Initial)**

Mailing Address _____

City_____ **State** _____**Zip** _____

Date of Birth _____ **Age** _____ **Gender** _____ **Last 4 digits SS#** _____ **Race** _____
Month/Day/Year Male/Female (optional)

Home Phone # _____ **Cell Phone #**_____ **Work Phone #**_____

	Yes	No
Is the person to be vaccinated sick today?	☐	☐
Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	☐	☐
Has the person to be vaccinated ever had a serious reaction after receiving a vaccination?	☐	☐
Has a physician ever diagnosed the person to be vaccinated with Guillain-Barré Syndrome (GBS)?	☐	☐

PLEASE TURN PAGE OVER AND COMPLETE OTHER SIDE

HEALTH DEPARTMENT USE ONLY

PCHD STATE VFC

Influenza	Influenza – High Dose	Pneumococcal
GSK SANOFI	Manufacturer: Sanofi 65 and Older	PPSV23 PCV13
LOT NUMBER / EXPIRATION	**LOT NUMBER / EXPIRATION**	**LOT NUMBER / EXPIRATION**
INJECTION SITE: RD LD	**INJECTION SITE: RD LD**	**INJECTION SITE: RD LD**

_____ _____
Nurse Signature **Date**

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

The PCHD Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice of Privacy Practices is subject to change. A copy of our Notice, is available upon request. By signing this form, you acknowledge that the PCHD Notice of Privacy Practices was made available to you.

CONSENT

You must be at least 18 years of age to sign. If under age 18, a parent or guardian's signature is required. I have been given, read or had explained to me the Vaccine Information Statement(s) for Influenza and/or Pneumococcal vaccine and understand the risks and benefits.

PAYMENT INFORMATION

Option 1: Pay the day of the clinic. Cash, check, (Lee Street ONLY MasterCard, VISA, and Discover credit/debit card) payments may be made on the day of the clinic.

Option 2: Assignment of Insurance Benefits (including Medicare) I request that payment of authorized insurance benefits be made to Putnam Health Department for services furnished to me or my dependent by the Department. Submission of insurance information does not guarantee coverage. I understand that if the insurance company does not cover the vaccine(s), I will be responsible for payment.

PRIMARY INSURANCE: ☐ None

Plan name: _____

ID Number: _____Group Number (if any):_____

Policy Holder: _____ _____ _____
(Last) (First) (Middle Initial)

Policy Holder Birth Date _____ Relationship to Policy Holder_____ Last 4digits SS # _____

SECONDARY INSURANCE: ☐ None

Plan name: _____

ID Number: _____Group Number (if any):_____

Policy Holder: _____ _____ _____
(Last) (First) (Middle Initial)

Policy Holder Birth Date _____ Relationship to Policy Holder_____ Last 4 digits SS # _____

_____ _____
Patient/Patient Representative's Signature **Date**

Health Department Use Only – Patient Pay

Amount Paid _____ **Cash** **Check** **Check #** _____

Receipt # _____ **Receipt issued by** _____