



Care. Protect. Educate.

11878 Winfield Road
Winfield, WV 25213
(304) 757-2541

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

Mailing Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Gender _____ Marital Status _____ 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, medications, food, latex 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)?	☐	☐
For women: Are you pregnant or is there a chance you could become pregnant?	☐	☐

PLEASE TURN PAGE OVER AND COMPLETE OTHER SIDE

HEALTH DEPARTMENT USE ONLY

PCHD STATE VFC

Influenza	Influenza - High Dose
Manufacturer: GSK 6 months and older	Manufacturer: Sanofi 65 and Older
_____ Lot number/Expiration	_____ Lot number/Expiration
_____ Injection Site: RD LD	_____ Injection Site: RD LD

Nurse: _____

Date: _____

ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES

The Putnam County Health Department (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 and/or Hepatitis A vaccine(s) today and understand the risks and benefits.

PAYMENT INFORMATION

Option 1: Pay the day of the clinic. Cash, check, (Health Department 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 the Putnam County Health Department for services furnished to me or my dependent by either 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

PLEASE PRINT

Plan name: _____

ID Number: _____ Group Number (if any): _____

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

Policy Holder Birth Date: _____ Relationship to Policy Holder: _____ 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: _____

Patient/Patient Representative's Signature

Date

Health Department Use Only – Patient Pay

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

Receipt # _____ **Receipt issued by** _____