Date of Service / / 16

TCHD FLU ENCOUNTER FORM

INSURANCE: ☐Medicaid ☐CHIP ☐PCN ☐Medicare ☐Private:

VFC ELIGIBILITY: ☐Not VFC Eligible ☐VFC Medicaid ☐VFC Uninsured Paid $:

Client's Name:_____ **Date of Birth:** _____ **Age:** _____
Last Name First Name

Address: _____ **City:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email address: _____

Race: _____ **Ethnicity:** ☐Hispanic or Latino ☐Not Hispanic or Latino **Sex:** ☐Male ☐Female

Primary Insurance: _____

Secondary Insurance: _____

If client is a minor: Parent/Guardian Name: _____

FLU SHOT: Complete the Screening Checklist for the Person to be Vaccinated:

NOTIFY THE NURSE IF YOU ANSWER "YES" TO ANY OF THE QUESTIONS.	YES	NO
1. Is the person to be vaccinated sick today? (The following are NOT contraindications: Mild illnesses, such as ear infections, colds, fever and diarrhea, or taking antibiotics.)	☐	☐
2. Do they have severe allergies to medications, food (i.e. eggs), a vaccine component or latex?	☐	☐
3. Have they had a serious reaction (e.g., Guillain-Barré syndrome), to a vaccine in the past?	☐	☐
4. Answer if child is 6 months thru 8 years of age: Have they had one or less flu vaccines?	☐	☐

ADDITIONAL VACCINES: Complete the Screening Checklist for the Person to be Vaccinated:

NOTIFY THE NURSE IF YOU ANSWER "YES" TO ANY OF THE QUESTIONS.	YES	NO
1. Have they had a brain or other nervous system problem, a seizure, or if they are a child, a parent or sibling with a history of seizures?	☐	☐
2. Are they pregnant, or is there a chance they could become pregnant during the next month?	☐	☐
3. Have they received any other vaccinations in the past four weeks?	☐	☐
4. Have they had a transfusion of blood, blood products or immune globulin in the past year?	☐	☐
5. Do they have cancer, leukemia, HIV/AIDS or other immune system problems?	☐	☐
6. In the past 3 months, have they taken drugs that affect the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐

Informed Medical Consent: I voluntarily consent/request for myself or the person I am legally responsible for, to vaccine(s). I have been given a copy of and have read, or had explained to me, the information contained in the VIS(s) about the disease(s) and vaccine(s) and understand the benefits and risks of the vaccine(s). I agree that this information may be shared with schools, day care centers, health care providers, and others to verify immunization status, for public health studies, or when medically necessary. I hereby release TCHD and their employees from all claims arising from such immunizations. **Billing:** I understand, as a courtesy to me, TCHD will bill my Medicaid/Medicare/Insurance and I hereby authorize them to do so. I understand I am responsible for any and all charges incurred if my insurance company denies payment for services rendered. If TCHD does not have a contract to bill my insurance company or if I do not have medical insurance, I understand I am responsible for payment in-full at the time of service. **HIPAA:** I am aware of TCHD's Notice of Privacy Practices, had an opportunity to ask questions and at my request, may receive a copy.

Client/Parent/Guardian Signature: _____ **Date:** _____

VACCINE	LOT	Site	Price	VACCINE	LOT	Site	Price
☐**INFLUENZA High Dose 65+**			**$ 62**	☐**PPV 23** 65+/19-64 hi-risk			**$ 88**
☐ **INFLUENZA Quad Inject 3+**			**$ 40**	☐**Tdap 7+** (☐Td 7+ $45)			**$ 61**
☐ **INFLUENZA Inject** 6-35 mos			**$ 40**	☐**Zostavax 50+**			**$210**
☐**PCV 13 0-2, 50+**			**$147**				

☐**A Royal, RN** ☐**L Heap, RN** ☐**L Ekenstam, RN** ☐**M Bateman, RN**