

## NYSDOH 2020-2021 Inactivated Flu Vaccine

FIRST NAME: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT #: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ GENDER: Male  Female

DATE OF BIRTH (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

IF UNDER 19 YEARS OLD: MOTHER'S FIRST & MAIDEN (LAST) NAME: \_\_\_\_\_

### PATIENT PAYMENT AGREEMENT

I authorize my Medicare and/or Medicaid benefits and, if applicable, Medigap benefits to be paid directly to the Rockland County Department of Health for any services furnished to me by that provider. I understand that charges not covered by my insurance company, as well as any applicable copayment or deductible, are my responsibility and are payable immediately upon receipt of my patient statement. I authorize the Rockland County Department of Health to release pertinent medical information about me to the Centers for Medicare & Medicaid Services and/or my Medigap insurer and their agents when requested or to facilitate payment of a claim.

MEDICARE/MEDICAID CARD #: \_\_\_\_\_

NAME OF PATIENT: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

Questions for the person receiving Vaccine (circle the appropriate answer). Screener Initials:	Yes	No
1. Is the vaccine recipient currently pregnant or a child under 3 years old?	Y	N
2. Are you currently moderately or severely ill with or without a fever?	Y	N
3. Have you ever developed Guillain-Barre syndrome within 6 weeks of getting a vaccine?	Y	N
4. Have you ever had a life-threatening allergy from a flu shot or from parts of the vaccine, including eggs, neomycin, aluminum or gelatin?	Y	N
5. Do you have any other severe, life-threatening allergies?	Y	N
6. Have you read or had read to you the Vaccine Information Statement for the flu (influenza) vaccine dated: 08/15/2019?	Y	N
7. Do you understand the risks and benefits of the vaccine and consent to getting the flu shot?	Y	N
8. Do you agree to give your doctor a copy of the flu shot record?	Y	N
9. If you are 19 or older: Do you consent to release your immunization record to NYSIS where it will be available to your healthcare provider?	Y	N

Date of Visit (MM/DD/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Fluzone</b> <b>Fluarix</b>	Left Deltoid      Right Deltoid      Left Thigh      Right Thigh
LOT #: _____	Total Administered: 1      Total Dispensed: 0
EXP. DATE: _____	Person Providing Vaccine: Name: _____

### FOR COUNTY EMPLOYEES ONLY

DEPARTMENT: \_\_\_\_\_ EXTENSION: \_\_\_\_\_ LAST 4 DIGITS OF SSN: \_\_\_\_\_