Public Health
Prevent. Promote. Protect.
Tuscarawas County Health Department

TUSCARAWAS COUNTY HEALTH DEPARTMENT
INFLUENZA/PNEUMONIA CLINIC FORM

PLEASE PRINT

Information needed for the person who will be receiving the vaccine:

Last Name: _____ First Name: _____ MI_____
Date of birth: _____ SSN: _____ Age: _____ Sex: _____
Address: _____
City: _____ County: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____

Insurance Information

Subscriber's Name: _____ Relationship to the patient: _____
Subscriber's DOB: _____ Subscriber's SSN: _____

For Patients Under 18 Years Old:
Parent/Guardian Name: _____ DOB: _____ SSN: _____

Consent/Notice of Privacy

By signing below, I understand that eligibility for coverage by my insurance company cannot be determined at this time. I understand that the services provided today may not be covered by my insurance company. If it is determined that I am not eligible for coverage and no benefits exist for my claim, I understand that I will be responsible for payment of all services provided.

I have received information concerning influenza and/or pneumonia vaccines. I was given a chance to ask questions about the influenza and pneumonia vaccines. I understand the benefits/risks of the vaccine. I ask the influenza and/or pneumonia vaccine be given to me or to the person named on this form for whom I am authorized to request. I have been offered and/or received a copy of the Notice of Privacy Practices, confirmed by my signature below.

Patient/Parent/Guardian Signature: _____ Date: _____

TCHD Staff will complete this section.

Vaccine Administered: Regular Dose Flu FluBlok (18+) High Dose Flu(65+) Prevnar-20

*317- 18 and over who is uninsured- only VFC under 18 who has MCD, underinsured or uninsured

	Private Stock- FLU	Private- Prevnar 20	VFC-317 FLU*
Vaccine Manufacturer			
Vaccine Lot Number			
Expiration Date, if needed			
Site of Administration			
Signature of Vaccine Administrator			

9/23ak