



Public Health
Prevent. Promote. Protect.

Tuscarawas County Health Department

**TUSCARAWAS COUNTY HEALTH DEPARTMENT
INFLUENZA/PNEUMONIA/RSV/COVID VACCINE FORM**

PLEASE PRINT

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

First Name: _____ Last Name: _____ MI _____

Date of birth: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____

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, pneumonia, RSV, and/or COVID-19 vaccines. I was given a chance to ask questions about the influenza and pneumonia vaccines. I understand the benefits/risks of the vaccines. I ask the influenza, pneumonia, RSV, and/or COVID-19 vaccines 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 Used: PRIVATE VFC 317

INFLUENZA	RSV	PREVNAR	COVID

- IMPACT
- EHR
- ZIP CODE _____
 - PRIMARY
 - VALID