Towns County Health Department Vaccine Questionnaire-Adult Flu Only

Client's Name:	Mailing Address:			
City:	County:	State:	Zip:	Phone:

(*Please Check One*)

	Female
	Male

Client's Date of Birth

(*month/day/year*)
Birthday

Age

(*Please Check One for Race*)

	Asian		Black/African American
	White		American Indian/Alaska Na
	Multicultural		Hawaiian or Polynesian
	Unknown		

(*Please Check for Ethnicity*)

	Hispanic/Latino
	Non-Hispanic/Non Latino
	Unknown

ANSWER THE FOLLOWING ABOUT THE PERSON RECEIVING THE IMMUNIZATION:	YES	NO	DO NOT KNOW	N/A
Is the person sick today?				
Does the person have allergies to latex, medications, food, or any vaccine?				
Has the person had a serious reaction to a vaccine in the past?				
Do you have a seizure, brain, or other nervous system problem?				
Do you consent to a nurse volunteer or student to administer the vaccine?				

How did you hear about this event?	Billboard	Newspaper	Website	Social Media	Radio	Friend/Family
(*Please check all that apply)*						

I have been given a copy and have read, or have had explained to me, the Vaccine Information Statement for the vaccine indicated above. I have been given an opportunity to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request it/they be given to me or to the client named above for whom I am authorized to make this request. I understand that it is recommended to wait at least 15 minutes at the clinical site after receiving the immunization in case of a reaction to the vaccine. I have been given the opportunity to review and/or receive, a copy upon request of, the Notice of Health Information Practices from the County Board of Health regarding my health information rights and the Board of Health responsibilities and I authorize the release of any medical or other information necessary for care, treatment and claim processing. I authorize payment of medical benefits to the undersigned physician, supplier or party who accepts assignment for services described. I understand I am responsible for payment if insurance denies payment.

_____ _____

Authorized Client and/or Guardian's Signature Date

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Dose/Rte: 0.5ml/IM

L___ R___ Deltoid

VIS Date: 08/06/2021

Nurse Signature_____ Date:_____

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No insurance _____

Medicare _____

Medicaid _____ (Amerigroup Peachstate Caresource)

Private _____ Type_____Member ID _____

******Please provide a copy of Insurance Card front and back*****