INFLUENZA (FLU) VACCINE

REGISTRATION FORM/CONSENT 2020-2021 INFLUENZA SEASON

SUSSEX COUNTY DIVISION OF HEALTH / OFFICE OF PUBLIC HEALTH NURSING

PLEASE PRINT NAME (last, first)			☐ Male ☐ Female
STREET			
CITY	STATE	ZIP	MUNI CODE
PHONE ☎		E-MAIL ADDRESS	
DATE OF BIRTH		AGE	

PRE-IMMUNIZATION QUESTIONNAIRE (Print form to answer the following questions)

Are you allergic to eggs or egg products?	YES	NO
Have you ever had a serious vaccine reaction after receiving a vaccination? • If yes, please describe:	YES	NO
Are you sick today or have you been sick within the past 24 hours? • If yes, please describe:	YES	NO
Have you ever had a seizure (convulsion), brain, or nervous system problem? *(PHN note)*	YES	NO
Have you ever had a paralytic illness called Guillain-Barre Syndrome? • If yes, was it after receiving a flu or pneumonia vaccine? ( )YES ( ) NO	YES	NO
Have you **ever** had a **FLU** vaccine **in the past?**	YES	NO
Have you **ever** had a **PNEUMONIA** vaccine? ( ) PCV 13 ( ) PPSV 23 • How many years ago did you receive the pneumonia vaccine?	YES	NO

INFLUENZA VACCINE CONSENT (Flu vaccine)

I received and read the information about Influenza disease, the vaccine, and special precautions. I have had the opportunity to ask questions that have been answered to my satisfaction. I verify that my answers on the Pre-Immunization Questionnaire are correct to the best of my knowledge.

I understand the benefits and risks of the influenza vaccine as described. I request that the influenza vaccine be administered to me or to the person named for whom I am authorized to sign.

Signature

VIS 08/15/19	
Manufacturer/lot # of vaccine	Signature of vaccine administrator

BILL TO

☐ Blue Cross/Blue Shield ☐ Medicare

NAME DATE OF BIRTH

ADDRESS

INSURANCE NAME MEMBER ID#

I authorize the Sussex County Division of Health (SCDH) to release related information regarding the above mentioned person to third party payers and to bill for service rendered to me if applicable. I request my payer to pay SCDH directly for services rendered to me.

Signature **Date**

SERVICES RENDERED

✓	*IMMUNIZATIONS*	*DX*	*CPT*	*FEE*		✓	*ADMINISTRATION FEE*	*CPT*	*FEE*
	INSURANCE-ADULT 18 years and older						**ADULT IMMUNIZATION ADMINISTRATION**		
	Influenza 3+ years quad no preservative	Z23	90686	$35.00			Single – IM/SC	90471	$25.00
	Influenza 3+ years quad with preservative	Z23	90688	$35.00			Each additional – IM/SC	90472	$25.00
	Influenza High Dose	Z23	90662	$60.00					
	MEDICARE-ADULT								
	Influenza Fluzone (Medicare)	Z23	Q2038	$35.00			Medicare flu administration	G0008	$30.00
	Influenza High Dose (Medicare)	Z23	90662	$70.00					
	CHILD UNDER 18 years old						**CHILD IMMUNIZATION ADMINISTRATION**	**CPT**	**FEE**
	Influenza 6-35 mos quad no preservative	Z23	90685	$40.00			Single – IM/SC	90471	$25.00
	Influenza 6-35 mos quad with preservative	Z23	90687	$30.00			Each additional – IM/SC	90472	$25.00
	Influenza 3+ years quad no preservative	Z23	90686	$30.00					
	Influenza 3+ years quad with preservative	Z23	90688	$30.00					

CLINIC DATE FORMS REVIEWED BY

COUNTY EMPLOYEE DEPARTMENT

VOLUNTEER/EMS