Riley County Health Department

INFLUENZA VACCINE REGISTRATION FORM

PATIENT INFORMATION

Patient's First Name | Middle Name | Last Name

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name(s))	Birth Date / /	Age	Sex ❑ M ❑ F

Race: ❑ Asian/Pacific Islander/Other ❑ Black or African American ❑ Caucasian or White ❑ Native American/Alaska Native ❑ Hawaiian ❑ Unknown or Other

Ethnicity: Hispanic/Latino?: ❑ Yes ❑ No

Current Address	City	State	ZIP Code

Cell Phone No. (text appointment reminders) ( )	Home Phone No. ( )	Preferred Language

Where has the patient previously received immunizations?

IN CASE OF EMERGENCY

Name of Emergency Contact	Relationship to Patient	Phone No. ( )	Additional Phone No. ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Is this patient covered by insurance? ❑ Yes ❑ No | Are immunizations covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance (Blue Cross, Aetna, Sunflower, etc.):

Subscriber's Name	Subscriber's Birth Date / /	Policy #	Group #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

IMMUNIZATION SCREENING QUESTIONNAIRE

1.	Is the person to be vaccinated currently sick or experiencing a high fever? If yes, please explain: _____	☐ Yes ☐ No
2.	Does the person to be vaccinated have allergies to medications, food, a vaccine component, or latex? If yes, please list:_____	☐ Yes ☐ No
3.	Has the person to be vaccinated had a serious reaction to a vaccine in the past? If yes, please explain: _____	☐ Yes ☐ No
4.	Has the person to be vaccinated ever had Guillain-Barré syndrome (neurological disorder)?	☐ Yes ☐ No
5.	Is the person to be vaccinated 19 years of age or older with one or more of the following medical conditions (recommend Flublok); pregnant (or thinking about becoming pregnant in the next year), asthma, chronic lung disease (COPD, cystic fibrosis), chronic heart disease (congestive heart failure, coronary artery disease), diabetic, obese, or have a weakened immune system (HIV, cancer, chronic steroids), or have another chronic (on going) medical condition not listed? **If so, please circle or list here… (FluBlok Screening)** _____	☐ Yes ☐ No ☐ < 19 years

VACCINE CONSENT

I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named above for whom I am authorized to make this request. ☒ Influenza

Signature of Patient or Legal Parent/Guardian: Date:

FOR OFFICE USE ONLY

Eligibility Screening	Nursing Documentation		Billing & Coding		
❑ **Title 19 (Public)**	**Manufacturer:**		**90662**	**High Dose (65+)**	**($55)**
❑ **Title 21 (Public)**	**Lot Number:**	*(place syringe sticker here)*	**90682**	**FluBlok (RIV4) (18+)**	**($55)**
❑ ***UN*insured ≤ 18 (Public)**	**Expiration Date:**		**90686**	**Fluarix**	**($20)**
❑ **Nat Am/Al Nat (Public)**			**317FLU**	**317 Flu Vaccine**	**($0)**
❑ ***UNDER*insured (Public)**	**Injection Site:**	Left Deltoid	**GRVAC**	**Grant Vaccine**	**($0)**
❑ **Fully Insured (Private)**		Right Vastus Lateralus			
❑ ***UN*insured ≥ 19 (Out of Pocket)**			**90471**	**1st Injection**	**($20)**
❑ ***UN*insured ≥ 19 (317)**	**Inadvertently administered (borrowed)**	❑	**G0008**	**Medicare Injection**	**($20)**
❑ **Grant Vaccine (Grant $)**	Private Public 317 (select one)		**90471G**	**Grant Injection**	**($0)**

Vaccine Administrator: **Date:**

RILEY COUNTY Health Department

Riley County Health Department
2030 Tecumseh Rd
Manhattan, Kansas 66502
Phone: 785-776-4779
Fax: 785-565-6565
www.rileycountyks.gov/health

Universal Consent Form

BILLING

By my signature below, I authorize the Riley County Health Department to bill any of the medical payers as indicated and provide necessary information to process claims. I authorize payment of medical benefits to the Riley County Health Department for services rendered and I understand I will be responsible for payment of charged deemed "uncovered" by my health insurance. This constitutes advance notice to you, the beneficiary, that if all program requirements are met by the Riley County Health Department and payment is not made by KanCare or your Health Insurance, you may be responsible for the charges. You may also be responsible for charged if you fail to inform the Health Department of Insurance coverage in a timely manner. The undersigned has read the above authorization and understands the same. I certify that the information provided is true and correct to the best of my knowledge for myself or the person named above for whom I am parent or legal guardian of and authorized to make medical decisions for.

If immunizations are not covered by your health insurance. These items are required to comply with federal regulations, to receive services through the Vaccine For Children program; a written statement, or explanantion of benefits claim from your Health insurance company stating immunizations are not covered. If we do not have a written statement prior to services the patient will be responsible for any portion that insurance will not cover. I consent for the inclusion of vaccines given as immunization data in the Kansas Immunization Registry for myself or the person named above for whom I am parent or legal guardian of and authorized to make medical decisions for.

It is your responsibility to verify that Riley County Health Department is an in-network provider for your insurance company. Charges will be the full price if Riley County is deemed a non-network provider after services are provided.

PRIVACY PRACTICES

All records of services rendered are considered confidential. I acknowledge that I have been offered a copy of the Riley County Health Department's Notice of Privacy Practices with the effective date of April 2019.

LABS / IMMUNIZATIONS

I have received information about the TB skin test. I had a chance to ask questions which were answered to my satisfaction. I agree to return in 48-72 hours to have the test read. I understand the risks and benefits of the TB skin test and request the test be given to me or the person named above for whom I am parent or legal guardian of and authorized to make medical decisions for.

I have been advised to wait for 15 minutes after vaccination at Riley County Health Department or outreach location.

DATA APPLICATION AND INTEGRATION SOLUTION FOR THE EARLY YEARS (DAISEY)

As part of the Kansas Department of Health and Environment Family Health Comprehensive System, we will enter your data collected within your family planning visits in an electronic system, Data Application and Integration Solution for the Early Years (DAISEY). The system is designed to keep your information secure. We will only use your information to track, evaluate, and improve reproductive health services you receive from us.

Information that will be entered in the system includes:

- Individually Identifiable Health information (Ex: name, gender, date of birth).
- Information about services you receive (Ex: health screening, education, home visits).
- Information about assessments you receive as part of a service (Ex: answers to questions about housing needs, tobacco use, prenatal care).

This notice is effective on the date below. Your signature acknowledges receipt of this notice but is not required. This notice will remain in effect until the organization destroys your information. You may ask to see your information at any time.

INTEGRATED REFERRAL AND INTAKE SYSTEM (IRIS)

By signing below I agree that my family/household members' information can be shared in IRIS with other service providers in my community's referral network who will also secure my information. All information is confidential and will only be shared for its intended purpose of providing wanted services to yourself and/or your family.

SIGNATURE _____ **DATE** _____

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Grant Eligibility Screening Tool
Uninsured

My signature verifies that the statement listed below about my insurance status is true and correct. The Riley County Health Department requires this statement for the purpose of providing immunizations using vaccine provided by state or federal programs.

I am an uninsured, meaning I have no health insurance, as of the date listed on this consent.

_____ _____
Patient Signature / Parent or Guardian Date

_____ _____
Patient Name (printed) Patient Date of Birth

Insurance Card

Front of Insurance Card:

Insurance Card

Back of Insurance Card: