Beaufort County Health Department
Statement of Permission and Assignment: Influenza Vaccine

Name: ____
Last **First** **Middle**

Gender: (circle) Male Female **Date of Birth:** ____________ **Social Security Number:** __________________

Address: ____
Number & Street

City ______________________________ **State** ____________________ **Zip** ____________________

Phone #: Home______________ Work/Other ___________ **Primary Language:** (circle) English Spanish Other

Race: (circle) White Hispanic African American Asian Native American Other

Insurance Information

☐ **Medicaid** Medicaid ID # ____________________________________

☐ **Medicare** Medicare Claim Number: ___________________________

☐ **No Insurance**

☐ **Private Insurance** Name of Insurance Company: ______________________________________

Policy # (or Subscriber ID#) ____

Group/Plan Name: _________________ Group #:____________

Pre-Vaccination Evaluation

I have read and understand the information provided to me about receiving vaccines for influenza (Current VIS form) and have had the opportunity to ask questions. I understand that being allergic to eggs may be a reason to not receive the vaccination for influenza. Please let us know if you

1) Have had an allergic reaction to eggs
2) Have had a serious reaction (including Guillan-Barre' Syndrome) after receiving influenza vaccine
3) Have a fever with a temperature above 100 degrees?

Signed Patient Consent

By Signing Below: I hereby acknowledge a copy of the "Notice of Privacy Practices" for the Beaufort County Health Department was available for me to read and/or receive a copy. _______ **(Please Initial)**

I authorize the Beaufort County Health Department to submit a claim on my behalf (if applicable) to Medicare, Medicaid, and/or private insurance or other third party payor. I also authorize release of any information necessary in processing my claim. I request payment be made to the Beaufort County Health Department on my behalf. **I am aware if my insurance does not pay I will be responsible for the bill.**

Signature: ____ **Date:** ____________________

FOR HEALTH DEPARTMENT USE ONLY

☐ **Fluzone (Private) UT8496KA Pres-free**	☐ Date_________
☐ **Fluzone (Private) UT843NA Pres-free**	Given By _________________ RN # _________
☐ **Fluzone (Private) UT8463AA HD**	
☐ **Fluzone (Private) U8499DA HD**	**Administration Site:** ☐ **Left Deltoid** ☐ **Right Deltoid**
☐ **Fluzone (Private) U8519BA HD**	☐ **Left Anterolateral Thigh** ☐ **Right Anterolateral Thigh**
☐ **Fluzone (Private) U8442AA**	**Diagnosis Code Z23**
☐ **Fluzone (Private) UA435BA**	**Pres-free Dosage and CPT Codes:**
☐ **Fluzone (state) UT8468MA**	☐ **0.50 ml CPT 90686 Presfree** ☐ **0.50 ml 90688**
☐ **Entered in Patagonia** ☐ **Entered in NCIR**	☐ **0.50 ml CPT 90662 (High Dose)**