RICHLAND COUNTY TB & HEALTH OFFICE

INFANT/CHILD/ADOLESENT FLU SCREENING FORM

	NO	YES
1. Is the person to be vaccinated sick or have a fever today?		
2. Does the person to be vaccinated have an allergy to eggs or any other allergy? List:		
3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?		
4. Does the child have asthma or any long term medical problems?		
5. Has the person to be vaccinated ever had Guillain-Barre syndrome (a disease causing temporary paralysis)?		
6. I have received the vaccine information sheet, had a chance to ask questions regarding the vaccine and understand the risks and benefits of the vaccine.		

WHICH OF THE FOLLOWING APPLY:
[ ] Medicaid
[ ] American Indian/ Alaskan Native
[ ] Insurance Name_____
[ ] Insurance DOES NOT pay for vaccines
[ ] No insurance

Patient's Age: _____ Patient's Dr. Name: _____

Patient's Name: _____

CHILD

Date of Service:_____ Patient's Name:_____

Home Address: _____ City:_____

Phone Number: _____ Zip Code: _____ Sex: (Circle One) M or F

Date of Birth: _____ Parent/Guardian's Name: _____

I authorize Richland County Health Office for immunizations given and to release service related information regarding the above mentioned person to third party payors and/or other health practitioners and to bill for service rendered to me if applicable. I request my payor to pay RCHO directly for services rendered to me.

Signature: _____ Date: _____

Check one	Vaccine Lot # & Expiration Date	Vaccine Name/Mfg/Description
		Fluarix GSK (IIV4) syringe (6 mo and up)
		Fluarix GSK (IIV4) syringe (6 mo and up)
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		Sanofi Fluzone (IIV4) syringe (6 mo and up)
		Sanofi Fluzone (IIV4) syringe (6 mo and up)

IM Deltoid L ___ R___ IM Leg L ___ R ___

Insurance Type: □ Insurance □ CHIP □ VFC

√	Flu Vaccinations	DX	CPT	Comp	Fee

√	Nursing Services	DX	CPT	Fee
	Brief Office Visit	Z23	99211	$30
	Component Administration	Z23	90460	$35

√	Special Diagnosis Codes

Total Charges for Services $ _____

Co-Pay $ _____

BALANCE DUE $ _____

□ Cash □ Credit /Debit

□ Check # _____

Nurse: _____

Update 9/27/2021