RICHLAND COUNTY TB & HEALTH OFFICE

ADULT 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 allergy:		
3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?		
4. Has the person to be vaccinated ever had Guillain-Barre syndrome (a disease causing temporary paralysis)?		
5. 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.		

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

Patient's Name: _____

ADULT

Date of Service:_____ Patient's Name:_____

Home Address: _____ City:_____

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

Date of Birth: _____

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
		Sanofi Fluzone (IIV4) syringe (6 mo and up)
		Sanofi Fluzone (IIV4) syringe (6 mo and up)
		Sanofi Flublok (IIV4) syringe (18 yrs and up)
		Sanofi Flublok (IIV 4) syringe (18 yrs and up)
		Sanofi Fluzone HD (IIV4) >65 yr
		Sanofi Fluzone HD (IIV4) >65 yr
		Sanofi Fluzone HD (IIV4) >65 yr

IM Deltoid L____ R____

Insurance Type: □ Insurance □ Medicare □ Medicaid □ Self Pay

√	Flu Vaccinations	DX	CPT	Fee

√				

√	Nursing Services	DX	CPT	Fee

√	Special Diagnosis Codes

Total Charges for Services $ _____

_____

Co-Pay $ _____

BALANCE DUE $ _____

□ Cash □ Credit /Debit

□ Check # _____

Nurse: _____

Update 9/27/2021