**RICHLAND COUNTY TB & HEALTH OFFICE**

**INFANT/CHILD/ADOLESENT FLU SCREENING FORM**

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|  | **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.** |  |  |

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| **WHICH OF THE FOLLOWING APPLY: [ ] Insurance Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **[ ] Medicaid [ ] Insurance DOES NOT pay for vaccines**  **[ ] American Indian/ Alaskan Native [ ] No insurance** |

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| Patient's Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient's Dr. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **ETHNICITY:** Hispanic or Latino Not Hispanic or Latino Unknown |
| **RACE:** American Indian or Alaska Native Black or African-American Hispanic or Latino  Asian Native Hawaiian or Other Pacific Islander Other race White Unknown |

Date of Service:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_

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

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Check one** | **Vaccine Lot # & Expiration Date** | **Vaccine Name/Mfg/Description** |
|  | (VFC) D34TF Exp. 6/30/23 | Fluarix GSK (IIV4) syringe (6 mo and up) |
|  | (VFC) Exp. | Fluarix GSK (IIV4) syringe (6 mo and up) |
|  | (CHIP) D34TF Exp. 6/30/23 | Fluarix GSK (IIV4) syringe (6 mo and up) |
|  | (P) UT7701KA Exp. 6/30/23 | Sanofi Fluzone (IIV4) syringe (6 mo and up) |
|  | (P) Exp. | Sanofi Fluzone (IIV4) syringe (6 mo and up) |
|  |  |  |
|  |  |  |

Insurance Type: □ Insurance □ CHIP □ VFC

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| **√** | **Flu Vaccinations** | **DX** | **CPT** | **Fee** |  | **√** | **Nursing Services** | | **DX** | **CPT** | **Fee** |
|  | Fluarix Syringe 6mo & up | Z23 | 90686 | $30 |  |  | Brief Office Visit | | Z23 | 99211 | $30 |
|  | Fluzone Syringe 6mo & up | Z23 | 90688 | $30 |  |  | Component Administration | | Z23 | 90460 | $35 |
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|  |  |  |  |  |  |  | Total charges for service $ | | | | |
|  |  |  |  |  |  |  | Balance Due $ | | | | |
|  |  |  |  |  |  |  | [ ] Cash [ ] Credit/ Debit [ ] Check # | | | | |
|  |  |  |  |  |  |  |  | |  |  |  |
|  |  |  |  |  |  | Nurse: | |  | | | |
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9/21/22