HENRY COUNTY PUBLIC health

Flu Vaccine

Section 1: Vaccine Recipient Information (Please Print)

Recipient Name: _____
Last First M.I.

Any other last names vaccination records might be under: _____

Address: _____
Street City State Zip Code

Age:_____ Date of Birth:_____ ☐ Male ☐ Female

Would you benefit from calming tools (i.e. weighted lap blanket, fidget toy, dimmed lights)? ☐ Yes ☐ No

Section 2: Screening for Vaccine Eligibility (for recipient)

Do you have an allergy to a component of the vaccine?	☐ Yes	☐ No
Have you ever had a serious reaction to the flu vaccine in the past?	☐ Yes	☐ No
Have you ever had Guillain-Barre syndrome?	☐ Yes	☐ No
Are you 65 or older?	☐ Yes	☐ No

Section 3: Insurance Billing

☐ I do not have insurance ☐ My insurance does not cover vaccines

I, the undersigned, certify that the information given by me in applying for payment under the insurance I provided, is correct. I authorize release of all records required to act on their request and request that payment of authorized benefits be made on my behalf or all who may be covered by this insurance. I authorize such insurance to make payment directly to Henry County Public Health.

I also understand that if the insurance DOES NOT pay, I may be billed for today's services.

Insurance Company Name:_____ Insurance #: _____

Policy Holder Name:_____ Date of Birth: _____ Sex: M ☐ F ☐

Signature: _____ **Date:** _____

Phone Number: _____

FLU VACCINE

FOR OFFICE USE ONLY

VFC VFA Insurance

Date:_____

Lot #: _____

Site: _____

Administered by_____

HIGH DOSE FLU VACCINE

FOR OFFICE USE ONLY

Date:_____

Lot #: _____

Site: _____

Administered by: _____