



# 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, cold spray, 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		
Healthcare Provider Use Only		
VFC	VFA	Insurance
Date:	_____	
Lot #:	_____	
Site:	_____	
Administered by:	_____	

HIGH DOSE	
FLU VACCINE	
Healthcare Provider Use Only	
Date:	_____
Lot #:	_____
Site:	_____
Administered by:	_____