INFLUENZA & COVID-19 IMMUNIZATION 2021-2022 CONSENT AND CLAIM FORM

MRN

How many members are in your family? __________

What is your annual household income (this includes spouse / partner)? __________

MEDICARE / MEDICAID

☐ #________ Medicare Part B	☐ #________ Oregon Health Plan (Medicaid)

PRIVATE INSURANCE

☐ ______________________ Name of insurance company | ______________________ Member #

______________________ Subscriber Name | ______________________ Subscriber Date of Birth

PATIENT INFORMATION (PLEASE PRINT) | Parent/Guardian Full Name: ______________________

Last Name:	First Name:	MI:
Date of Birth: (mo/day/yr) ____/____/____	Phone#: (______) ______–______	☐ F ☐ Other **Sex:** ☐ M

Street and/or Mailing Address:

City:	State:	Zip:	Primary Language:

Race: (Check all that apply) ☐ African American ☐ American Indian/ Alaskan Native ☐ Asian ☐ Native Hawaiian/ Pacific Islander ☐ White ☐ Decline to Answer

Ethnicity: Hispanic? ☐ Yes ☐ No ☐ Decline

	Question	Yes	No	Don't Know
1.	Is the person being vaccinated here for their: 1st COVID vaccine ☐ 2nd COVID Vaccine ☐ 3rd COVID vaccine ☐ or COVID Booster Vaccine ☐			
2.	Does the person to be vaccinated have a fever or feel sick today?	☐	☐	☐
3.	Does the person to be vaccinated have any allergies to eggs, medicines, foods, latex, or vaccines?	☐	☐	☐
4.	Has the person to be vaccinated ever had a severe allergic reaction (e.g., anaphylaxis) to something?	☐	☐	☐
5.	Has the person to be vaccinated ever fainted after injections?	☐	☐	☐
6.	Has the person to be vaccinated ever had a positive test for COVID-19 or has a doctor ever told the person to be vaccinated that they had COVID-19?	☐	☐	☐
7.	Has the person to be vaccinated received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
8.	Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), anemia, another blood or bleeding disorder, are taking a blood thinner, or have a history of Guillain-Barré Syndrome?	☐	☐	☐
9.	Does the person to be vaccinated live with, or expect to have close contact with, a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	☐	☐	☐
10.	Is the person to be vaccinated pregnant, planning to become pregnant, or breastfeeding?	☐	☐	☐

I have read/had explained to me the information about COVID-19 and the COVID-19 vaccine (Fact Sheet) and/or influenza and the influenza vaccine (VIS sheet). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of COVID-19 vaccine and/or influenza vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I agree that Tillamook County Community Health Centers shall have no responsibility or liability if I contract COVID-19, influenza, or other respiratory diseases, or suffer any other adverse reaction following administration of the COVID-19 or flu shot. I allow the release of any information needed to process insurance claims or request payment of medical benefits. **THERE IS NO COST FOR COVID VACCINE OR ADMINISTRATION.** There may be out-of-pocket costs for administration fee of influenza and/or pneumonia vaccines. I understand that I am responsible if payment is denied by my insurance carrier.

X ______________________ **Signature of responsible person** ______________ **Date**

FOR OFFICE USE ONLY

Question 1, for 3rd dose check applicable line: ___Active cancer and or Tx. ___Organ transplant ___Stem cell transplant ___Moderate or severe primary immunodeficiency ___HIV ___Active Tx. With high-dose corticosteroids or other drugs that may suppress the immune system.

Question 3 list any allergies/reactions:______________________________

Question 6: If yes, when? Must be out of isolation (10 days). ______________________________

Question 7: If yes, when? Must be 90 days since treatment. ______________________________

Question 8: If yes, what______________________________

Monitoring Time ___15 minutes ___30 Minutes

Contraindications

FluMist: Only for ages 2 through 49 years. Contraindicated in Asthma and immune compromised. A person a with a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs, or receiving antiviral medications should not receive flu mist. Should also **not** receive flu mist if they live with an immunocompromised individual.

All Flu: Guillain-Barré Syndrome, anaphylaxis reaction to eggs, severe reaction to a previous flu vaccine.

COVID-19: Allergy to any component of the vaccine or severe reaction to a previous COVID-19 vaccine.

Severe Reaction: Full body rash, swelling in face or neck, anaphylaxis.

SELF-PAY					
☐ Cash ☐ Check	**Flu**	☐ $0 ☐ $15	☐ $30 ☐ $65 (HD)	**Pneumo** ☐ $15	☐ $103 (Pneumovax) ☐ $202 (Prevnar 13)

COVID-19										
Dose:	.2	.25	.3	.5	**Site:**	RDIM	LDIM	RVLIM	LVLIM	
MODERNA					**PFIZER PEDS**				**PFIZER ADULT**	
041J21A	4/28/22	059H21A	5/27/22		FK5618	2/28/22	FL8095	2/28/22	FH8027	5/31/22

INFLUENZA

Dose: .2 .5 .7 **Site:** RDIM RVLIM LDIM LVLIM NASAL
Inj. Exp: 6/30/22

PLACE PF STICKER HERE

PLACE PNEUMO STICKER HERE

PRIVATE INS OR $30 (ALL AGES) & INSURED ADULTS – Use "L" Code (BLUE)		VFC (OHP or No Ins. ONLY) (0-18 yrs ONLY – NO ADULTS) (GREEN)		FLU POOL (No ins. ADULTS ONLY – "S" Code) (RED)	
FluMist	**PF Syringe**	**FluMist**	**PF Syringe**	**FluMist**	**PF Syringe**
NK2075 1/13/22	UJ742AB (HD)	NH3062 12/14/21	UJ776AA		3T4DH
	UJ748AA (HD)		UT7347MA	CPT 90688 Admin 90471	
	UJ769AB (HD)			**MDV**	
	UJ776AA				
	UT7330LA				
	UT7376LA				

PNEUMONIA

Dose: .5 **Site:** RDIM LDIM

PPV23 Lot#	Exp. Date	PCV13 Lot#	Exp. Date
T033369	5/26/22	DJ7719	8/31/22
U002528	9/13/22	DN4218	1/31/23
U010533	10/29/22	EE3119	4/30/23
		EH9810	6/30/23

Nurse: ____________ **Clinic Location:** ____________ **Date:** ____________ ☐ Entered in EPIC

Rev. 12/20/2021

FluMist CPT 90672
FluMist admin 90473