LOGAN COUNTY INFLUENZA VACCINE ADMINISTRATION RECORD

PATIENT INFORMATION

Name ____ **Date of Birth**_______________ **Age**______

Mailing Address _________________________ **City** ________________ **State** ____ **Zip Code** _______

Phone Number_______________________ **Gender: Male Female** **Household Size**__________

INSURANCE INFORMATION

I would like Logan County Health Department to bill:

- ❑ **My Employer** __________________________**has contracted with Logan County Health Department**
- ❑ **My insurance** ____ **(Must provide current copy of card)**
- ❑ **I do not have health insurance coverage.**
- ❑ **I am paying by cash or check#**________________ **(Please circle one)**

HEALTH SCREENING	**(Circle One)**
Is the person to be vaccinated sick today?	Yes or No
Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	Yes or No
Does the person to be vaccinated have an allergy to eggs or egg products?	Yes or No
Has the person to be vaccinated ever had Guillain-Barre Syndrome (GBS)?	Yes or No

I have been offered a copy of the "Vaccine Information Statement" and ask that the Influenza Vaccine be given to me or to the person named for whom I am authorized to make this request. The Logan County Health Department may release my medical information to my insurance provider, as necessary to receive payment. I understand any amount not covered by insurance is my responsibility. LCHD participates in electronic health information for billing and immunization registry purposes. For a notice of privacy practices patients may request a copy from LCHD.

Recipient/Parent/Guardian Signature ______________________________________ Date_______________

********************CLINICAL USE ONLY********************

Vaccine: Influenza Dx: Z23 CPT: 90686 90662 90682 VIS: 8/6/2021	Inj. Site: L R Delt / Vas Lat	**2022/23 Influenza Season**
Administered by:	❑ Cash or Check #___________ ❑ Insurance card copied ❑ Contract Pay	Date: