

## PEF Label

Name: \_\_\_\_\_  
First
Middle
Last

Address: \_\_\_\_\_  
Street
City
County
State
Zip Code

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
 (\_\_\_\_-\_\_\_\_-\_\_\_\_)

SSN: \_\_\_\_\_ Birthdate (MM-DD-YYYY) \_\_\_\_\_ Age: \_\_\_\_\_  
 (\_\_\_\_-\_\_\_\_-\_\_\_\_) (\_\_\_\_-\_\_\_\_-\_\_\_\_)

Sex:  Male  Female Ethnicity:  Non-Hispanic/latino  Hispanic/latino  
 Race:  White  Black/African American  Native Hawaiian/Pacific Islander  American Indian/Alaska Native  
 Asian  Multi-racial

School-age child  Yes  No School \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_  
 Do you have Medicaid?:  Yes  No Medicaid Number: \_\_\_\_\_  
 Do you have Medicare?:  Yes  No Medicare Number: \_\_\_\_\_  
 Do you have Insurance?:  Yes  No Insurance Name: \_\_\_\_\_  
 Policy ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

### FLU Vaccine

**Yes No Medical History Questions**

- Has the individual had a past history of Guillan-Barre syndrome within 6 weeks following a previous flu vaccine?
- Has the individual eaten eggs and had difficulty breathing (Anaphylactic reaction)?
- Has the individual had a fever in the past 24 hours?
- Is the individual taking Theophylline or Warfarin (blood thinner)?
- Is the individual allergic to any medicine or latex? \_\_\_\_\_

"I have read or have had explained to me the information sheet: *Inactivated Influenza Vaccine, "What You Need To Know"* (VIS Dated 08/06/2021), or *Influenza Vaccine (Live, Intranasal); "What You Need To Know"* (VIS Dated 08/06/2021),

I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request.

I also understand I may be tested for HIV infection, Hepatitis B, or any other disease carried by blood or body fluids if such a test(s) is needed if a health care worker is exposed to my blood, body fluids or tissue.

I request that payment of authorized medical insurance benefits be made to **Franklin County Health Department** on my behalf or behalf of my child, for services received. I also authorize the local health department to release medical information to Medicare, Other Third Payors (insurance carriers, Medicaid, etc.) and their agents to determine payment for services. I am aware that should Medicare refuse payment for this service, I will be responsible for the cost. If I am covered by a billable private insurance, I am aware that I may be responsible for some additional charges not covered by my plan.

*Administration Record: The health department may keep this record in a medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the vaccine injection site, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.*

I have received or been offered the HIPAA privacy notice (online at FCHD.org)

X \_\_\_\_\_ DATE: \_\_\_\_\_  
 Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian/representative)

**Franklin County Health Department**

Influenza Vaccine Year 2021-2022

**FOR HEALTH DEPARTMENT USE ONLY**

✓	<b>Required for all vaccines</b>		
	CPT 80000 Unspecified procedure	ICD 10 Code Z23. Encounter for immunization	M1184 Provider: Jacqueline Klee NPI# 1215028766

*Jacqueline Klee apm*  
**Signature of Provider**

**Vaccine** \_\_\_\_\_  Left Deltoid  Right Deltoid  
**Manufacturer** \_\_\_\_\_  Left Anterolateral Thigh Muscle  Right Anterolateral Thigh Muscle  
**Lot #** \_\_\_\_\_ **Injection Site**  Intranasal

**Signature & Title of Provider:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **VFC**  Yes  No  
**FFC**  Yes  No

**FLU Self Pay - \$30.00 Quadrivalent, \$65.00 High-Dose**  Cash  Check # \_\_\_\_\_  Credit Card  Visa  Mastercard  Other

✓	<b>Influenza (KVP/VFC, Adult Stimulus or MEDICAID)</b>		✓	<b>Influenza (NON-KVP, Private Insurance, Self-Pay, Medicare)</b>	
	90460	Admin of Influenza under 19 yrs of age Unit 1		G0008	Admin of Flu Vaccine Private Insurance
	90471	Admin of Influenza over 19 yrs of age		90686NV	IIV4 PF, 6 months & above
	90672	LAIV4 Intranasal FluMist ages 2-49 yrs		90662	IIV PF, HIGH DOSE, age 65 yrs & above
	90686	IIV4 PF, 6 months & above			
	90686FR	IIV4 PF, 19 yrs and older - no insurance			
	90686NV	IIV4 PF, 19 yrs and older - Medicaid			