Franklin County Health Department
100 Glenns Creek Rd Frankfort, Ky 40601
COVID-19 and Flu Vaccine Administration Record

PEF label

DOCUMENT#: _____

HID/LOC/SITE: _____

Administration: _____

NAME: _____ **ID/SOCIALSECURITY#:** _____

ADDRESS: _____ _____ _____ _____ _____
STREET *CITY* *COUNTY* *STATE* *ZIP*

PHONE NUMBER: _____ **Email:** _____

BIRTHDATE: _____ _____ _____
MONTH *DAY* *YEAR*

SCHOOL-AGE CHILD: _____ **SCHOOL:**_____ **GRADE:** _____ **HOMEROOM TEACHER:**_____

SEX: _____ **RACE:** _____ **ETHNICITY:** _____

How many in the HOUSEHOLD: _____

DO YOU HAVE **MEDICAID**? _____ IF YES, **MEDICAID NUMBER**: _____ **MCO NUMBER:** _____

DO YOU HAVE **MEDICARE**? _____ IF YES, **MEDICARE NUMBER**: _____

DO YOU HAVE **HEALTH INSURANCE**? _____ IF YES, **COMPANY NAME:** _____
SUBSCRIBER NAME: _____ **POLICY ID:** _____ **GROUP #**_____

FLU VACCINE MEDICAL HISTORY QUESTIONS:

	Yes	No
Has the patient had Guillan-Barre syndrome within 6 weeks following a previous flu vaccine?		
Has the patient eaten eggs and had difficulty breathing (anaphylactic reaction)?		
Has the patient had a fever in the past 24 hours?		
Is the patient taking Theophylline or Warfarin (blood thinner)?		
Is the patient allergic to any medicine or latex?		

I have read or have had explained to me the information sheet: Influenza Vaccine, (Inactivated or Recombinant) what you need to know (VIS dated 8/6/2021).

I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine. I understand the benefits and risks of the Covid-19 vaccine, the Covid-19 dosing intervals and attest that I meet all eligibility requirements to receive the requested Covid-19 vaccine.

I also understand I may be tested for HIV, 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-Party Payers (insurance carriers, Medicaid, etc.) and their agents to determine payment for services. I am aware that should Medicare refuse payment for this service, I may 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.

The health department may keep this record in a medical file. They will record what vaccines were given, when the vaccines were given, the name of the company that made the vaccines, the vaccines' lot number, the vaccine injection sites, the signature and title of the person who gave the vaccines, and the address where the vaccines were given. I give my informed consent for the vaccines to be given to me or to the person named above for whom I am authorized to make this request.

X_____**DATE:** _____
Signature of person to receive vaccines or person authorized to make the request (parent or legal guardian/representative)

FOR HEALTH DEPARTMENT USE ONLY **ENTERED IN KYIR: DATE**_____ **INITIALS:** _____

Flu:

Procedure Code: 80000 (unspecified procedure) **ICD-10:** Z23. (Encounter for immunization)

Vaccine Manufacturer/Lot number: _____ **Injection Site:**_____

Signature and Title of Provider:_____ **Provider #** _____ **Date:**_____

	Influenza (VFC, Adult Stimulus or MEDICAID)			**Influenza (NON-VFC, Private Insurance, Self-Pay, Medicare)**	
	90460	Admin of Influenza age 18 and below, **1** Unit		G0008	Admin of Flu Vaccine Private Insurance
	90471	Admin of Influenza age 19 and above		90656NV	IIV3 PF, 6 months & above (Fluzone or Fluarix)
	90656	IIV3, 6 months-18 yrs **VFC** (FluLaval)		90662	IIV3-HD, HIGH DOSE, age 65 yrs & above (Fluzone)
	90660	LAIV3, 2yrs-18 yrs **VFC** (FluMist)		90673NV	RIV3, AGE **18 yrs and older** (Flublok)
	90661	ccIIV3, 6 months -18 yrs **VFC** (Flucelvax)			
	90656FR	IIV3, 19 yrs and above – **No Insurance** (Afluria)			
	90656NV	IIV3 PF, 6 months & above (Fluzone or Fluarix)			

VFC _____ **FFC** _____

FLU PRICING: Trivalent $35.00, High-dose $85.00, Adult Stimulus $5.00, VFC-Sliding scale based on income

Amount Paid: _____ Staff Initials:_____ Payment Method: _____ Check # _____

COVID:

Procedure Code: 80000 (unspecified procedure) **ICD-10:** Z23. (Encounter for immunization)

Vaccine Manufacturer/Lot number: _____ **Injection Site:**_____

Signature and Title of Provider:_____ **Provider #** _____ **Date:** _____

√	**COVID-19 VACCINE:**		
√	**Administration:**		
	90480 Administration of COVID-19 vaccine, single dose		
	90480FR Administration of COVID-19 vaccine, single dose for **UNINSURED ADULTS**		
	VFC (**under 19yrs**: Medicaid, uninsured, underinsured)		**NON-VFC:** (over 19 yrs: **Adult Stimulus**, Medicaid, Medicare, commercial insurance)
	Pfizer:		**Pfizer:**
	91318 - .2mL (6 months-4 years)		91318NV - .2mL (6 months-4 years)
	91319 - .2mL (5 – 11 years)		91319NV - .2mL (5 – 11 years)
	91320 - .2mL (12-19 years)		91320NV - .2mL (12 years +)
			91320FR - .2mL (12 years+, uninsured)
	Moderna:		**Moderna:**
	91321 - .25 mL (6 months-11 years)		91321NV - .25 mL (6 months-11 years)
	91322 - .5mL (12-19 years)		91322NV - .5mL (12 years +)
			91322FR - .5ml (12 years+, uninsured)

Amount Paid: _____ Staff Initials:_____ Payment Method: _____ Check # _____