Public Health
Prevent. Promote. Protect.
Le Sueur County

Le Sueur County Public Health
2017-2018 Influenza Vaccine

Last Name | First Name | Middle I. | Gender | Date of Birth

Gender: Male / Female

Street Address | City | State | Zip Code | Phone Number

Physician's Name | Physician's Clinic | Phone Number

Payment Information: MEDICARE CLIENTS MUST COMPLETE THE BACK OF THIS PAGE

Insurance (circle one) | Insurance ID Number | Group Number

Medicare MA Blue Plus UCare
BC/BS Medica Humana
Health Partners Preferred One

Policy Holders Name, if different from person receiving the vaccine | Policy Holder's Relationship

☐ Cash ☐ Check ☐ Voucher ☐ MnVFC Eligible _____

Health History:

Yes	No	
☐	☐	Are you sick today? (fever of 100.5 or higher on the day of the clinic)
☐	☐	Have you ever had Guillain-Barre Syndrome within 6 weeks of an influenza vaccination?
☐	☐	Are you allergic to **eggs**? Do you get hives when you eat eggs? ☐ Yes ☐ No
☐	☐	Do you have a ***life-threatening*** allergy to anything, such as **antibiotics** or **gelatin**? Please explain:_____
☐	☐	Have you ever had a reaction to a dose of flu vaccine that needed immediate medical attention?

Agreement: I have read or had explained to me the Vaccine Information Statement (8/7/15) "Influenza Vaccine: What You Need to Know." I have had the chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccination be given to me or to the person named above for whom I am authorized to make this request. **PLEASE NOTE IN THE EVENT OF NON-PAYMENT/PARTIAL PAYMENT TO LE SUEUR COUNTY PUBLIC HEALTH BY YOUR INSURANCE, YOU WILL BE HELD RESPONSIBLE FOR THE PAYMENT AND WILL RECEIVE SUCH STATEMENT/INVOICE.**

Signature of Patient or Legal Guardian:_____ Date: _____

CLINIC STAFF TO COMPLETE BELOW THIS LINE

Clinic Site: Office Le Center Montgomery Waterville Homecare Client School_____ Business/Other_____

Vaccine	Date Administered	Route	Injection Site	Dose	Vaccine Manufacturer	Lot Number Expiration Date VIS Date	Nurse Initials
Influenza		IM		0.5 ml 0.25 ml	Sanofi		

TO PERSONS WITH MEDICARE

Medicare regulations require that this agency ask each person about other insurances that would pay for services. Medicare will pay for services only when it has been determined that there is no other payment source. To meet this regulation, Medicare requires that you answer the following questions:

1. Are you currently working full or part-time? _____Yes _____No

2. If married, is your spouse currently working full or part-time? _____Yes _____No

3. Are you covered under an employer group health plan based on your current employment, or the employment of your spouse? _____Yes _____No

4. If **YES**, please complete the following; if **NO** go to question 5.

   Name of Insured_____

   Relationship to Medicare beneficiary_____

   Name and Address of insurance_____

   Group ID #_____Policy ID #_____

5. Are you entitled to Black Lung Medical benefits? _____Yes _____No

6. Is this service for treatment of a work related injury or illness _____Yes _____No

7. If **YES**, please complete the following; If **NO**, go to question 8.

   Name/Address of worker's compensation agency_____

   Name/Address of employer_____

8. Is this service for the treatment of an illness or injury which resulted from an automobile liability or no-fault accident? _____Yes _____No

9. If **YES**, please complete the following:

   Name/Address of insurer_____

   Policy number of insurance_____

_____ _____

Signature of Medicare Client Date