Le Sueur County Public Health
2022 - 2023 Influenza Vaccine

Last Name: | **First Name:** | **Middle I.**

Street Address: | **City:** | **State:** | **Zip Code:**

Email Address: | **Phone Number:** | **Date of Birth:**

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

Insurance

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

Not Accepted: United Health, Unicare or Assurant

Insurance ID Number:
Primary:
Secondary:

Group Number:
Primary:
Secondary:

☐ 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 (8/15/19) "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 Community Clinic Homecare Client School_____ Business/Other_____

Vaccine	Date Administered	Route	Injection Site	Dose	Vaccine Manufacturer	Lot Number: Expiration Date: 6/30/2023	Nurse Initials
Influenza		IM		0.5 ml	Sanofi	UT7680MA UT7689NA	

*** PERSONS WITH MEDICARE **ONLY** CONTINUE WITH THIS SECTION ***

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:

Last Name:	First Name:	Middle I.

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