Clear Form

OTTER TAIL COUNTY · MINNESOTA

# Influenza Vaccine Form
# 2019-2020

Public Health
Prevent. Promote. Protect.

## Contact Information- Person being vaccinated (Please Print)

Last Name | First Name | MI

Street Address | City

State | Zip | Phone | Date of Birth

Immunization information may be shared through the Minnesota Immunization Information Connection (MIIC) with other healthcare providers, schools, health departments, and others authorized under law to receive it. If you have questions, please ask your health care provider. If you decide not to have this information shared with MIIC, please call 1-800-657-3970

Assignment of Benefits and Responsibilities for Payment: I authorize Otter Tail County Public Health Department to bill this health plan for services received and for same services to be paid directly to Otter Tail County Public Health

### Payment Information

Primary Insurance Carrier:

Policy Number: | Group #:

Secondary Insurance Carrier:

Policy Number: | Group #:

☐ No Insurance

*If you have no insurance and would like to pay the administration fee, you can make a check payable for $21.22 to Otter Tail County Public Health*

Agreement

I have read or had explained tome the Vaccine Information Statement "Influenza Vaccine: What You Need to Know." 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. I also acknowledge that a copy of the Notice of Privacy Practices has been available to me.

_____ _____

Signature of Person receiving the flu shot or Legal Guardian | Date

**Health History**

| Yes | No | | |
|---|---|---|---|
| ☐ | ☐ | 1. | Are you sick today? (Fever of 100.5 or higher on the day of the clinic) |
| ☐ | ☐ | 2. | Have you ever had Guillain-Barré Syndrome within 6 weeks of an influenza vaccination? |
| ☐ | ☐ | 3. | Do you have a life-threatening allergy to eggs? |
| ☐ | ☐ | 4. | Do you have a life-threatening allergy to a component of the vaccine? May include antibiotics, gelatin or latex. |
| ☐ | ☐ | 5. | Have you ever had a reaction to a dose of flu vaccine that needed immediate medical attention? |

**For Clinic Use Only**

**Vaccine Label Here:**

**Administered By**: _____

**Injection Site:** Deltoid ☐ Left ☐ Right ☐ Date:
Thigh ☐ Left ☐ Right ☐