FULL NAME: _____

First Name M Last Name

DATE OF BIRTH: _____ AGE: _____

STATE EMPLOYEE ONLY

STATE EMPLOYEE ONLY: YES_____NO_____

LAST 4 OF SS#_____

CIRCLE GENDER: MALE FEMALE

STREET ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____PHONE NUMBER:_____

CIRCLE RACE: WHITE BLACK/AFRICAN-AMERICAN ASIAN AMERICAN INDIAN OTHER: _____

CIRCLE ETHNICITY: HISPANIC/LATINO NON-HISPANIC/LATINO

CIRCLE PREFERRED LANGUAGE: ENGLISH SPANISH OTHER

INSURANCE PRIMARY:_____ID#_____GROUP#_____

SECONDARY:_____ID#_____GROUP#_____

**Do you have any allergies? (eggs, chicken, latex or medicines)	Circle: YES NO
Have you ever had a **REACTION to a flu shot before:	Circle: YES NO
**Do you currently have an active illness or are your taking antibiotics?	Circle: YES NO
**Have you had Guillain-Barre Syndrome?	Circle: YES NO
**Have you traveled outside of the US within the last 30 days?	Circle: YES NO
**Have you been in contact with anyone who has traveled outside of US within the last 30 days?	Circle: YES NO

If you answer "yes" to any of the above questions, please let the nurse know

JOINT NOTICE OF PRIVACY PRACTICES GIVEN

I HAVE READ OR HAD THE INFORMATION ABOUT THE INFLUENZA VACCINE EXPLAINED TO ME. I WAS GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I UNDERSTAND THE BENEFITS AND RISKS OF THE INFLUENZA VACCINE AND REQUEST THE VACCINE BE GIVEN TO ME OR THE PERSON FOR WHOM I AM AUTHORIZED TO MAKE THIS REQUEST. I UNDERSTAND THAT THE IMMUNES GIVEN TODAY WILL BE ENTERED INTO THE STATE DATA BASE, UNLESS I DECLINE. THE LAST FOUR DIGITS OF YOUR SOCIAL SECURITY NUMBER IS SO THAT YOUR BILL WHEN SUBMITTED CAN BE READILY IDENTIFIED AND PAID .

X _____

PRINTED NAMED

X _____ _____

SIGNATURE of person receiving vaccine or parent/guardian **DATE**

AGENCY USE ONLY PP STOCK ONLY

FLU VACCINE
SITE:_____

2021-2022
VIS GIVEN:____
8/6/2020
LOT#_____
EXP DATE:_____
FLUBLOK:_____

FLUZONE QUAD: _____
HIGH DOSE: _____

Office Use Only: **BILLING**
Clinic Site: _____
Payment: _____ cash/check/cc#_____
Medicare _____ Private Insurance _____ IPA Adult____
Bill Township _____
Bill County for Employee/dependent: _____
State Employee:_____

SIGNATURE OF NURSE ADMINISTERING VACCINE:_____

9/23/2020

ROCK ISLAND COUNTY HEALTH DEPARTMENT

UNITED HEALTH CARE

UMR

BLUE CROSS BLUE SHIELD (PPO PLAN)

MEDICAID

MERIDIAN

ILLINICARE

YOUTHCARE

BLUE CROSS COMMUNITY HEALTH PLAN (MEDICAID)

MEDICARES

AETNA

COVENTRY

HUMANA

MEDICARE PART B

UNITED HEALTH CARE MEDICARE SOLUTIONS

UNITED HEALTH CARE AARP

UNITED HEALTH CARE MEDICARE COMPLETE

***PEOPLE WHO DO USE INSURANCE (EVEN THOUGH THEY ARE LISTED ABOVE) ARE RESPONSIBLE FOR FINDING OUT IF THEIR INSURANCE COVERS VACCINES AND CONFIRM THAT ROCK ISLAND COUNTY HEALTH DEPARTMENT IS WITHIN NETWORK.

NO HMO INSURANCES ARE ACCEPTED AT THIS HEALTH DEPARTMENT.

STATE EMPLOYEE WORKERS ONLY WE WILL BILL THE STATE DIRECTLY

IF NO INSURANCE THE FEE FOR REGULAR FLU IS $35 AND FOR HIGH DOSE IS $55