Flu Form
Pender County Health Department
803 S. Walker Street, Burgaw, NC 28425
910-259-1230

YOU MUST COMPLETE ALL FIELDS BELOW:

Information collected on this form will be used to document authorization for receipt of vaccine(s).

Patient's Name: (Last, First, Middle Initial)	**Social Security Number:**

Date of Birth: (mm/dd/yyyy)	**Gender: (Check One)**	**Ethnicity: (Check One)**
	☐ **Male** ☐ **Female**	☐ **Hispanic** ☐ **Non-Hispanic**

Race: (Check all that apply)

☐ **White** ☐ **Black or African-American** ☐ **Native Hawaiian or Other Pacific Islander**
☐ **Asian** ☐ **American Indian or Alaskan Native**

Address:	**Health Insurance:** **Attach Copy of Card** ☐ **Medicare** ☐ **Medicaid** ☐ **Private** ☐**None**

City:	**County**	**State**	**Zip Code**

Home Telephone Number: ( )	**Work Telephone Number:** ( )

Emergency Contact: Name (First & Last)	**Phone Number:** ( )	**Relationship:**

MINORS ONLY: Mother's Maiden Name: (Last, First, Middle Initial)

PLEASE ANSWER ALL OF THE FOLLOWING:

1. Are you currently pregnant? ☐ **YES** ☐ **NO**
2. Do you have any acute/chronic medical conditions such as heart disease, diabetes, asthma, cancer or any condition that affects your immune system? ☐ **YES** ☐ **NO**
3. Have you ever had a reaction to a previous dose of influenza vaccine? ☐ **YES** ☐ **NO**
4. Do you have an allergy to eggs? ☐ **YES** ☐ **NO**

I am authorized by the parent, guardian, or person standing in loco parentis of the above-named child to obtain needed immunizations for the child.

I/parental designee have received the "Vaccine Information Statements" (VIS) about the disease(s) and vaccine(s). I have had a chance to review the VIS(s) and to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and request the vaccine(s) indicated below to be given to me or the person named above for whom I am authorized to make this request.

SIGNATURE – Person to receive vaccines or person authorized to sign on patient's behalf: ✕	Date Signed:

FOR OFFICE USE ONLY

Eligibility: ☐ **Medicare** ☐ **Medicaid** ☐ **Not Insured** ☐ **Underinsured** ☐ **NC Health Choice** ☐ **Insured** _____

Payment: **Amount Paid: $**_____ ☐ **Cash** ☐ **Credit Card** ☐ **Check**

Vaccine	Trade Name	Lot #	VIS Pub. Date	Date VIS Presented	Body Route	Body Site*	mL.
Influenza			08/07/2015		IM	RV LV RD LD	
PNEUMOVAX			04/24/2015		IM / SQ	RV LV RD LD	
PREVNAR 13			11/05/2015		IM	RV LV RD LD	

* **RV** = Right Vastus Lateralis **LV** = Left Vastus Lateralis **RD** = Right Deltoid **LD** = Left Deltoid

Nurse Signature:	**Date:**

ADMINISTRATION FEE	**VACCINE CODE**
90471 Administration 1 Vaccine	**Clinic Type (Circle one): AH CH** **State**_____ **PVT**_____
90472 Administration 2+ Vaccine	**90687** Multi-dose 6mos-35mos **90685** Preservative Free 6mos-35mos **90732** Pneumovax
90473 Admin. Nasal/Oral ONLY	**90688** Multi-dose 3yrs & older **90686** Preservative Free 3yrs & older **90670** Prevnar 13
90474 Admin. Nasal/Oral add-on	**90662** **High Dose** – 65+ Only **90682** Flublok - 50-64 yrs **90672** Flumist
G0008 Flu Admin.- **Medicare** Only	
G0009 Pneumonia-**Medicare** Only	
DIAGNOSIS	**Z23**– Influenza **Z23** – Pneumonia