Flu, RSV, Covid, Shingrix, Pneumonia Vaccination Form

Jersey County Health Department
1307 State Hwy 109, Jerseyville IL 62052

Demographics - ***Patient - Complete all Highlighted Areas***

Name: ______________________________ **M.I.**______ **Date of Birth**:____/____/_____ **Age**:_________ **Gender:** M F

Address:______________________________ **City:**______________ **State:**____ **Zip:**__________ **Phone:**______________

Race: Black/African American White/Caucasian Other____________________ **Ethnicity:** Hispanic/Latino Not Hispanic/Latino

COMPLETE THIS SECTION ONLY IF YOU HAVE INSURANCE COVERAGE

☐ Medicaid: MCO → ABH BCCHP Meridian Molina YouthCare

☐ Title XXI/CHIP

☐ Medicare #: ______________________________

☐ No Insurance

☐ Private Insurance: Aetna BC/BS Cigna Coventry Health Alliance Healthlink Humana United Health Care

Member ID #: ______________________________ Group #: (if applicable) ______________________________

Policy Holder: ______________________________

☐ Vaccine Given at Home

Put an "x" in the box below to indicate that you have the HIPAA information.

☐ **HIPAA** – I understand a *Notice of Privacy Practices* is available at my request. Under the Healthcare Insurance Portability and Accountability Act, I authorize JCHD to disclose my Immunization Record to my physician and/ or school. I also authorize the following person(s) to have access to my records:
(*It's OK if you don't write anyone's name)* ____

Screening Checklist for Contraindications to Vaccinations

The following questions help us determine if there is any reason, we should not administer vaccines today. A "yes" does not mean you can't be vaccinated, but we may need to ask additional questions. Please ask if a question is not clear.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?			
2. Has the patient had an allergic reaction to: ☐ Anything that required a use of an EpiPen or hospital stay. ☐ Polyethylene glycol, which is found in some medications, such as laxatives and preparations for colonoscopy procedures. ☐ Polysorbate, which is found in some vaccine, film coated tablets, and IV steroids. ☐ eggs			
3. Does the patient have a history of myocarditis or pericarditis?			
4. Has the person to be vaccinated ever had Guillain Barré syndrome?			
5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?			

"I completed this form to the best of my knowledge. I have been given, read and understand the possible side effects that could be caused by the vaccine(s) as described in the Vaccine Information Statement (VIS). I give my consent for the vaccine to be given as indicated. I authorize JCHD to release service-related information about me to third-party payors and to bill for services rendered to me. I agree to pay JCHD for the vaccine(s) if it is not covered or paid by my insurance, and I understand that JCHD may bill me for this amount."

Signature: ____ **Date:** ______________________

(Patient or parent/ legal guardian must sign) *Print Parent/Legal Guardian name*:

*** Place stickers for Vaccines Administered below***

Office Use Only *

Nurse reviewing form/giving vaccine: ______________________________ Date Reviewed/Administered:____________________

VIS dates Flu 8/6/2021, RSV 7/24/2023, Zoster 2/4/2023, PCV/PPSV 05/12/2023 and 10/30/2019