

# Kanawha-Charleston Health Department

108 Lee Street, East  
Charleston WV 25301

## 2016-2017 Seasonal Influenza/Pneumococcal Vaccination Consent/Administration Form

Name \_\_\_\_\_  
(Last) (First) (Middle Initial)

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Last 4 digits SS# \_\_\_\_\_ Race \_\_\_\_\_  
Month/Day/Year Male/Female (optional)

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

	Yes	No
Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>
Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>
Has the person to be vaccinated ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician ever diagnosed the person to be vaccinated with Guillain-Barré Syndrome (GBS)?	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE TURN PAGE OVER AND COMPLETE OTHER SIDE**

### HEALTH DEPARTMENT USE ONLY

**KCHD STATE VFC**

Influenza		
GSK	SANOFI	
LOT NUMBER / EXPIRATION		
INJECTION SITE:	RD	LD

Influenza – High Dose		
SANOFI 65 AND OLDER		
LOT NUMBER / EXPIRATION		
INJECTION SITE:	RD	LD

Pneumococcal		
PPSV23	PCV13	
LOT NUMBER / EXPIRATION		
INJECTION SITE:	RD	LD

\_\_\_\_\_  
**Nurse Signature**

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES**

The KCHD Notice of Privacy Practices provides information about how we may use and disclose your protected health information. The Notice of Privacy Practices is subject to change. A copy of our Notice, is available upon request. By signing this form, you acknowledge that the KCHD Notice of Privacy Practices was made available to you.

**CONSENT**

You must be at least 18 years of age to sign. If under age 18, a parent or guardian’s signature is required. I have been given, read or had explained to me the Vaccine Information Statement(s) for the 2016-17 Influenza and/or Pneumococcal vaccine and understand the risks and benefits.

**PAYMENT INFORMATION**

**Option 1: Pay the day of the clinic.** Cash, check, (Lee Street ONLY MasterCard, VISA, and Discover credit/debit card) payments may be made on the day of the clinic.

**Option 2: Assignment of Insurance Benefits (including Medicare)** I request that payment of authorized insurance benefits be made to Kanawha-Charleston Health Department for services furnished to me or my dependent by the Department. Submission of insurance information does not guarantee coverage. I understand that if the insurance company does not cover the vaccine(s), I will be responsible for payment.

**PRIMARY INSURANCE:**  None

Plan name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number (if any): \_\_\_\_\_

Policy Holder: \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial)

Policy Holder Birth Date \_\_\_\_\_ Relationship to Policy Holder \_\_\_\_\_ Last 4 digits SS # \_\_\_\_\_

**SECONDARY INSURANCE:**  None

Plan name: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number (if any): \_\_\_\_\_

Policy Holder: \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial)

Policy Holder Birth Date \_\_\_\_\_ Relationship to Policy Holder \_\_\_\_\_ Last 4 digits SS # \_\_\_\_\_

\_\_\_\_\_  
**Patient/Patient Representative’s Signature**

\_\_\_\_\_  
**Date**

**Health Department Use Only – Patient Pay**

**Amount Paid** \_\_\_\_\_ **Cash** \_\_\_\_\_ **Check** \_\_\_\_\_ **Check #** \_\_\_\_\_

**Receipt #** \_\_\_\_\_ **Receipt issued by** \_\_\_\_\_