REGISTRATION AND CONSENT FOR SERVICES
COMMUNITY HEALTH AND PREVENTION SERVICES
DEKALB COUNTY BOARD OF HEALTH

INFORMATION ON PERSON TO RECEIVE SERVICES **(PLEASE PRINT)**

Last Name	First Name	Middle Initial	Birthdate	Age

Address	Apt No.	City	County	State	Zip code

Phone#: ____________________
Home: ____________________
Work: ____________________
Other: ____________________

Race:
_____ **Black (B)** _____ **Hispanic White (Z)** _____ **American Indian (I)**
_____ **White (W)** _____ **Hispanic Black (X)** _____ **Alaska Native (E)**
_____ **Asian (A)** _____ **Multi-racial (M)**

Sex
_____ **Male**
_____ **Female**

Marital Status:
_____ **Married (M)** _____ **Divorced (D)**
_____ **Single (S)** _____ **Widowed(W)**

Insurance Carrier
Member ID #
Group #

Medicaid # / Medicare Part B# (circle one)

I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Statement(s) for the vaccines checked below. I have had the opportunity to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines requested and ask that the vaccines checked be given to the person named for whom I am authorized to make the request. I authorize the release of this immunization record to other healthcare providers on request.

☐ Influenza ☐ Influenza Nasal ☐ Pneumococcal ☐ Td/Tdap ☐ Hepatitis A ☐ Hepatitis B ☐ HPV ☐ Meningococcal ☐ Hepatitis A/B combo ☐ TB Skin test

SIGNATURE OF PERSON AUTHORIZED TO MAKE REQUEST	DATE OF SIGNATURE

FOR OFFICE USE ONLY

Vaccine	State Eligible code (VFC)	State Eligible code (GIP)	Not Eligible	Site	VIS (Mo/Yr)	Route	Provider	MFG	Lot #	Fee
Influenza Vaccine (flozone- High dose) 65 yrs & older (Trivalent)	n/a	n/a	FLHD		8/7/2015	IM				$65.00
Influenza Vaccine (fluzone 1 dose vail) 36mos & older Sanofi (Quadrivalent)	FLVV	n/a	FLUZ		8/7/2015	IM				$21.93/$30
Influenza Vaccine (fluzone) vial 6 mos - 35 mos Sanofi (Quadrivalent)	FLC	n/a	FLM		8/7/2015	IM				$21.93/$30
Influenza Vaccine (fluzone) no preserv 6 mos to 35 mos (Quadrivalent)	FLCF	n/a	n/a		8/7/2015	IM				$21.93/$30
Influenza Vaccine (fluarix) no presv 36mos & older GSK (Quadrivalent)	FLUX	n/a	FL4		8/7/2015	IM				$21.93/$30
Influenza Vaccine (fluzone) 6mos & infinity	FLQ	n/a	FLU		8/7/2015	IM				$21.93/$30
Influenza Vaccine - no presv (fluvirin) vial 4 yrs & older	FLVF	n/a	FLVX		8/7/2015	IM				$21.93/$30
Influenza Vaccine (fluvirin) vial 4 yrs and up	FLV	n/a	FLVA		8/7/2015	IM				$21.93/$30
Influenza Vaccine (Afluria) no presv 9 yrs & older	FLT	n/a	FLTX		8/7/2015	IM				$21.93/$30
Influenza Vaccine (fluzone Intradermal) no preserv 18-64 yrs Sanofi	n/a	n/a	FLID		8/7/2015	ID				$30.00
Influenza Vaccine (fluzone syring) 36 mos & older, Sanofi (Quadrivalent)	FLW	n/a	FLWZ		8/7/2015	IM				$21.93/$30
Pneumo 13 (PCV)	PNU	n/a	PCX		11/5/2015	IM				$21.93/$155
Penumo 23 (PPSV)	n/a	PNV	PNE		04/24/15	IM				$21.93/$98
MMR	MMR	MMA	MMX		4/20/12	SC				$21.93/$65
Varicella	VZV	VZA	VZX		3/13/2008	SC				$21.93/$125
Hep A > 19	n/a	HAH	HAA		7/20/16	IM				$21.93/$65
Hep B > 19	n/a	HBA	HBV		7/20/16	IM				$21.93/$67
Hep A/B	n/a	AAB	ABH		7/20/16	IM				$21.93/$90.00
Menactra	MEN	n/a	MEX		7/20/16	IM				$21.93/$130
HPV	HPV	HPA	HPX		12/2/16	IM				$21.93/$160
Meningococcal	n/a	n/a	MCV		3/31/16	IM				$145.00
Meningococcal B (Beexsero)	BEXS	n/a	BEXX		3/31/16	IM				$21.93/$185
Meningococcal B (Trumenba)	TRUM	MEE	TRUX		3/31/16	IM				$21.93/$134
Menveo	MEV	n/a	MNV		3/31/16	IM				$21.93/$130
TDAP	TDP	TPA	TDT		2/24/15	IM				$21.93/$55
Kinrix (DTap/IVP)	KNRX	n/a	n/a		5/17/07-7/20/16	IM				$21.93
PPD Skin Test	n/a	n/a	PPD		X	SQ				$24.00
Medicare Flu Adm. Fee	n/a	n/a	AFL			X				26.16
Medicare PNE Fee	n/a	n/a	APN			X				26.15
Medicare HBV Adm. Fee	n/a	n/a	AHB			X				26.15
Insurance Co-pay HBV	n/a	n/a	ICO			X				$10.00
Administrative Fee — SHBP	n/a	n/a	90471	X	X	X	X	X	X	$23.00
Administrative Fee — SHBP	n/a	n/a	90472	X	X	X	X	X	X	$21.00
Administrative Fee — SHBP	n/a	n/a	90474	X	X	X	X	X	X	$20.00

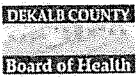
Method of Payment
☐ Cash
☐ Check # __________
☐ Credit Card
☐ Medicare ____________________
☐ Blue Cross/Blue Shield

☐ Medicaid __________
☐ Invoice __________
☐ Cigna
☐ United Health Care
☐ Aetna
☐ Coventry

Amount Paid ____________________

____
Nurses Signature

____
Date



Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

PATIENT NAME ______________________

DATE OF BIRTH ____ / ____ / ____
month / day / year

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to a component of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	☐	☐	☐

FORM COMPLETED BY ______________________ DATE __________

FORM REVIEWED BY ______________________ DATE __________