POD Influenza Vaccine Form for 2020

HN2 Site for Data Entry: **Clarke Mobile** Client ID #: _____

Date of Service: _____

Highest Trained Provider: _____ Additional Providers: _____

Enrollment Info: Mother's Maiden Last Name: _____ *Responsible Person Email*: _____

Responsible Person Info: *Last Name:* _____ *First Name:* _____

(for clients under age 18) *Race:* _____ *Sex:* _____ *Birthdate:* _____

Relationship: _____ *Address:* _____

City, State and Zip: _____ *Phone:* _____

Financial Responsibility: POD = POD

Financial Eligibility: A = Native American / Alaskan Native M = Insured Vaccines covered OR No Imm. Today

I = Underinsured / Insurance Doesn't Cover N = No Insurance

Screening Checklist for Contraindications: Reviewed

Imm. Up to Date for Age after Visit: Y = Yes

Interval to Next Imm: **Circle one:** 1 month 1 year

Reason for no HN2 consent: F – Consent on FLU form

VIS Names: Flu, Inactivated *or* Flu, live VIS Date: 8/15/2019

Inventory Code: Clarke Mobile

Data Entry to Complete	Initials
HN2 Client Register; Insurance; Signature	
HN2 Encounter	

HN2 Code	Vaccine Description	Source	Age Range Dosage/Route	Manufacturer Trade Name	NDC	Lot #	Site / Route
FV4P	**Flu (IIV4, pres-free; SDS)**	**NonSt 90686**	**> = 6m 0.5 mL**	**GSK Fluarix Quad**	**58160-0885-52**		**LD LVL / RD RVL / Intramuscular**

1. Private Fluarix for > = 6 month
2. State Fluarix for > = 6 month
3. State Flucelvax for > = 4 year
4. State FluMist for 2 year – 49 year

- 6m – 23m:
  - may receive (FV4P) injectable Fluarix private vaccine; screen for eligibility (if insured = will bill; if not insured = will waive for POD; if non-par will waive for POD)
  - may receive (FV4V) injectable Fluarix state vaccine; screen for eligibility (if insured = will bill; if not insured = will waive for POD)
- 2y – 3y age clients:
  - may receive (FV4P) injectable Fluarix private; screen for eligibility (if insured = will bill; if not insured = will waive for POD; if non-par will waive for POD)
  - may receive (FV4V) injectable Fluarix state vaccine; screen for eligibility (if insured = will bill; if not insured = will waive for POD)
  - may receive (FI4V) FluMist state vaccine; ***no screening*** for eligibility = waive for POD
- 4y – 18y age clients:
  - may receive (FV4P) injectable Fluarix private vaccine; screen for eligibility (if insured = will bill; if not insured = will waive for POD; if non-par will waive for POD)
  - may receive (FV4V) injectable Fluarix state vaccine; screen for eligibility (if insured = will bill; if not insured = will waive for POD)
  - may receive (FCC4V) injectable Flucelvax state vaccine; screen for eligibility (if insured = will bill; if not insured = will waive for POD)
  - may receive (FI4V) FluMist state vaccine; ***no screening*** for eligibility = will waive for POD
- > = 19y age clients:
  - may receive (FV4V) injectable Fluarix state vaccine; ***no screening*** for eligibility = will waive for POD
  - may receive (FCC4V) injectable Flucelvax state vaccine; ***no screening*** for eligibility = will waive for POD
  - may receive (FI4V) FluMist state vaccine; ***no screening*** for eligibility = will waive for POD

FV4V	**Flu (IIV4, pres-free; SDS)**	***StSupl* 90686**	**> = 6m 0.5 mL**	**GSK Fluarix Quad**	**58160-0885-52**		**LD LVL / RD RVL / Intramuscular**
FCC4V	**Flu (ccIIV4, pres-free; SDS)**	***StSupl* 90674**	**> = 4y 0.5 mL**	**Seqirus Flucelvax Quad**	**70461-0320-03**		**LD LVL / RD RVL / Intramuscular**
FI4V	**Influenza (LAIV4, SDS)**	***StSupl* 90672**	**2y - 49y 0.2 mL**	**MedImmune FluMist Quad**	**66019-0307-10**		**Nose / Intranasal**

I GIVE CONSENT to DPH District 10 for the patient named above to receive the influenza vaccine. I acknowledge that the patient and medical information provided above is correct. I have been given a copy of and have read (or have had explained to me) the information in the Vaccine Information Statement (VIS) for the influenza vaccine. I have been given an opportunity to ask questions and they were answered to my satisfaction. I believe I understand the benefits and risks of the influenza vaccine and request it be given to me or to the patient named above for whom I am authorized to make this request. I understand that it is recommended to wait at least 15 minutes at the clinical site after receiving the immunization in case of a reaction to the vaccine.

CHILDREN 18 YEARS OF AGE OR YOUNGER WITH INSURANCE: By providing insurance information for a child 18 years of age or younger I authorize DPH District 10 to bill my insurance for appropriate reimbursement and payment.

Patient/Guardian Signature:_____ Relationship:_____ Date:_____

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Section 1: Information about Patient to Receive Influenza Vaccine (please print)

PATIENT NAME (Last) If applicable, Suffix	(First)	(M.I.)	PATIENT'S MAIDEN NAME	COUNTY OF RESIDENCE
PATIENT BIRTHDATE (mm/dd/yyyy)	PATIENT AGE	GENDER Male Female	Mother's Maiden Last Name for GRITS	
ETHNICITY *(Please Circle)* Not Hispanic/Latino Hispanic Latino	RACE *(Please Circle)* Asian Black White Multi-racial Native American/Alaska Native Native Hawaiian/Other Pacific Islander		MARITAL STATUS (Please circle) Single Married Divorced Separated Widowed	
MAILING ADDRESS			PHONE NUMBER (home, mobile, work)	
CITY STATE		ZIP CODE	E-MAIL (personal, work)	
EMERGENCY CONTACT PERSON NAME	RELATIONSHIP		PHONE NUMBER FOR EMERGENCY CONTACT PERSON	

For children 18 years of age and younger please complete the insurance section below; if 19 years or older skip to section 2.

INSURANCE INFORMATION: Do you have insurance that covers vaccines?

☐ Yes, patient has insurance coverage; Please check insurance below:

- ☐ Aetna ☐ Cigna ☐ PeachCare
- ☐ Ambetter ☐ Coventry ☐ United Healthcare
- ☐ Blue Cross Blue Shield ☐ Tricare East/Life ☐ Medicare
- ☐ Medicaid *includes* (Amerigroup, CareSource, Peach State or Wellcare)

☐ Other insurance not listed above: _____

☐ No, patient does not have insurance

Provide the insurance information & attach a copy of the insurance card to this form *if possible*

Policy Holder Name _____

Member ID # _____

Group # _____

Section 2: Medical Information: *The following questions will help us to determine if this person can receive the influenza vaccine.*

Please circle Yes or No for each question.

1.	Is the person to be vaccinated sick today?	Yes	No
2.	Has the person to be vaccinated received any other vaccinations in the past 4 weeks? If yes, please list:	Yes	No
3.	When was the person last vaccinated for influenza?	**DATE:**	
4.	Does the person to be vaccinated have an allergy to a component of the influenza vaccine?	Yes	No
5.	Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	Yes	No
6.	Does the person to be vaccinated have a long-term health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, liver disease, metabolic disease (e.g., diabetes), or have a cochlear implant or spinal fluid leak, or no spleen?	Yes	No
7.	If the person to be vaccinated is **age 2 through 4 years**, in the past 12 months, has a healthcare provider told you the person had wheezing or asthma?	Yes	No
8.	Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that affect the immune system (e.g., prednisone or other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or anticancer drugs) or have they had radiation treatments?	Yes	No
9.	Is the person to be vaccinated receiving or has recently received influenza antiviral medications?	Yes	No
10.	Is the person to be vaccinated **age 6 months through 17 years** and receiving aspirin- or salicylate-containing medicine?	Yes	No
11.	Is the person to be vaccinated pregnant or could the person become pregnant within the next month?	Yes	No
12.	Has the person to be vaccinated ever had Guillain-Barré syndrome?	Yes	No
13.	Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	Yes	No

Section 3: CONSENT & INSURANCE: *If this consent form is not filled in completely, signed and dated, the patient will not be vaccinated.*

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Patient/Guardian Signature:_____ Relationship:_____ Date:_____