

Influenza Screening form 2016



Client's Name _____ Date of Birth _____ Age: _____

Mailing Address _____ City _____

State _____ Zip Code _____ Phone (____) _____

Parents _____ Mother's Maiden Name _____

Is the individual Hispanic or Latino? YES NO Circle: Male Female

Race: White American Indian more than one race other/unknown

If you have insurance please call them to verify immunization coverage prior to completing this form – Thank You. RCHD is not responsible to inform you of what your insurance will or will not cover. You will be responsible for any balance.

Determining VFC

Do you have health insurance that covers vaccines Yes or No

Do you qualify for IHS (Indian Health Service) Yes or No
Or other federally funded insurance

Is your child enrolled in Healthy Montana Kids Plus (Medicaid) Yes or No



Cost & Method of Payment

******If your child 0-18 yrs. of age does not have insurance, qualifies for IHS, or your insurance does not cover vaccines, the cost is \$21.32 per immunization.******

Please photocopy front and back of insurance card and bring with form

The RCHD **only bills the following insurances**

- | | |
|---------------------------------------|------------------|
| *Healthy Montana Kids Plus (Medicaid) | *Cigna |
| *Healthy Montana Kids (Chips) | * BC/BS |
| *EBMS | * Pacific Source |
| *Medicare | |

If you have health insurance that covers immunizations and it is not on the list of insurances that we bill, the cost per shot is listed below. Payment is required at the time of service and a charge sheet will be provided for you to submit to your insurance for reimbursement purposes.

Influenza (90685) 0-3 yrs: \$45.00
Influenza (90686) 3+ yrs: \$32.00
High Dose Influenza(90662) 65+ yrs: \$60.00

I give permission for Richland County Health Department to enter my vaccine information into the electronic statewide immunization registry. This information will only be shared with health care providers as necessary.

Client Signature _____ Date _____

For Nurses Only	<u>Influenza VIS form date: 8-7-2015</u>	VFC	Left	Deltoid
		PRIVATE	Right	Thigh
				Nasal
Date: _____				
Form Reviewed/Vaccinator Signature: _____				

Please fill out reverse side

SCREENING QUESTIONS

	Don't Know	No	Yes
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to the influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider ever told you that he or she had wheezing or asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the person to be vaccinated have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the person to be vaccinated receiving antiviral medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. 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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>Form completed by: _____ Date: _____</p> <p>Form reviewed by: _____ Date: _____</p> <p style="text-align: center;"> Technical content reviewed by the Centers for Disease Control and Prevention www.immunize.org/catg.d/p4067.pdf Item #P4067 (8/12) Immunization Action Coalition 1573 Selby Ave. St. Paul, MN 55104 (651) 647-9009 www.immunize.org www.vaccineinformation.org </p>			

For Office Use Only: Influenza VIS form date: 8-7-2015

New Client _____ (this fiscal year)

Return Client _____ (this fiscal year)