For Office Use Only

Medicaid Medicare Paid BC/BS

ID Number:_____

Group No: _____

Policy Holder: _____

Influenza Vaccine Documentation/Consent Form

☐ Regular Flu
- (Ages 6 months+)

☐ Flublok
- (Ages 18+)
- (Egg Free)
- (Recommended for ages 50+)

☐ High Dose Flu
- (Ages 65+)

I have been offered or provided, whether accepted or not, a copy of the "Vaccine Information Statement" dated 08/06/2021. I have read, or have had explained to me, the information in the "Vaccine Information Statement." My questions have been answered satisfactorily, and I ask that the vaccine be given to me or to the person named below for whom I am authorized to make this request. (If applicable, I authorize the Ellis County Health Department to bill my insurance or my Medicare Part B for this vaccination.)

X_____ _____

Signature of Patient (or) Parent/Guardian Date

Patient Information

Last:_____ First:_____ M.I._____ Male/Female

(Circle One)

Date of Birth: _____ Age: _____ Primary Race:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Are you allergic to eggs or egg products? ☐ Yes ☐ No

Vaccine Provided and Administered by: Ellis County Health Department
2507 Canterbury Drive, Hays, Kansas 67601 785-628-9440

FOR CLINIC USE ONLY

VIS Date: 08/06/2021

Lot Number_____ _____Left _____Right

Expiration Date_____ _____Deltoid _____Vastus Lat

_____ _____

Signature and Title of Vaccine Administrator Date

Acknowledgement of Notice of Privacy Practices

Patient Name: _____

Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. It also provides information on your rights regarding your protected health information as outlined by the Health Insurance Portability and Accountability Act of 1996.

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by making a request to Ellis County Health Department.

Communication

We may notify you of upcoming appointments by phone, email or text. We may leave messages on your voicemail asking you to contact our office for information. We will only communicate medical information to you by phone. Please let us know if you prefer alternative means to communicate with you.

My protected health information may be disclosed to the following people involved in my care.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

I acknowledge that I have received a copy of the **Ellis County Health Department** Notice of Privacy Practices with the effective date of April 14, 2003

_____ _____

Signature of Patient or Guardian Date