UnityPoint Health - Grinnell Public Health **2020 - 2021 Flu Vaccination Release Form**

Name _____
Last *First* *Middle Initial*

Address _____

City _____ State _____ Zip Code _____ Phone Number _____

Birthdate ____/____/____ Age _____ Gender: ❑Male ❑Female

Yes	No	
❑	❑	1. Is this your first flu vaccination?
❑	❑	2. Have you ever had a **severe** reaction to a flu vaccine?
❑	❑	3. Are you allergic to chicken, eggs, chicken feathers, latex or the preservative thimerosol?
❑	❑	4. Have you ever had Guillain-Barre Syndrome (central nervous system disease that causes paralysis) within 6 weeks of receiving the flu shot?
❑	❑	5. Do you have an acute illness with fever now, or in the past 2 days?
❑	❑	6. Are you experiencing any signs/symptoms of COVID-19?

Check ONE box to indicate payment of services **Attach Copy of Insurance Card**

❑ Medicare Part B: ID #: _____

❑ Medicare HMO Name: _____ ID #:

Claims Address: _____

❑ Medicaid ❑ Iowa Total Care: ID #: _____

❑ Hawk - I ❑ Amerigroup: ID #: _____

❑ Other Insurance

Insurance Name: _____ ID #: _____ Group #: _____

Insurance Policy Holder's Name: _____

Claims Address: _____

❑ I have no insurance or my insurance does not cover immunizations.

❑ $30 flu shot ❑ $10 VFC admin fee ❑ $50 high dose flu shot

❑ Cash

❑ Check # _____

❑ Credit Card _____

❑ Bill to Employer (please write employer's name) _____

I have read or have had the information relating to the influenza vaccine available to me - VIS provided - Published 8/15/19 I have had a chance to ask questions and these have been answered to my satisfaction. I understand the benefits and risks of influenza vaccine and ask that the vaccine is given to me, or to the person named above for whom I am authorized to make this request. I accept re-sponsibility for seeking medical attention for any problems with this vaccination. I acknowledge availability of the Notice of Privacy Practices for UnityPoint Health - Grinnell Regional Medical Center (HIPAA statement) by my signature below.

Signature _____ **Date** _____

For Clinic Use Only

VFC PP High Dose Flu Blok	Flulaval Lot #: Fluzone Lot #:	RD LAT LD RAT	Dose: IM 0.5 mL IM 0.7 mL	Nurse Signature: Date: