

Covid

Macon County Health Department

Flu

Flu & COVID-19 Assessment Screening / Consent Form for Drive Thru Clinic

Bill Emp. Insurance CK / Cash / CC

First name: Last name: Age:

SS # DOB: Gender: Race: Hispanic or Non

Home address:

City: State: Zip: Phone:

Insurance Plan Name:

Insurance Id Number: Group:

If covered under parent/spouse's plan (their info is needed)

Name: DOB:

Phone: Gender: Relationship:

Please answer the following questions

Table with 4 columns: Health History, YES, NO, UNKNOWN. Rows include questions about feeling sick, contact with sick people, allergies, immune system problems, Guillain-Barre syndrome, and pregnancy.

Please Read and Sign Below

This record will be kept on file at the Macon Co. Health Dept. It will include when the vaccine was given, the name of the vaccine manufacturer, lot number, and injection site. I have read and been offered a copy of the Vaccine Information Statement and have had the opportunity to ask questions and had them answered to my satisfaction. I understand the benefits of receiving the vaccine(s) and give my consent to receive the injection(s). I give consent for my insurance (if applicable) to be billed, and if denied, I understand that I am responsible for the payment in full. By signing below, I acknowledge that I have been offered a copy and/or read the HIPAA Privacy Act and agree to the statements above.

Signature: Date:

FLU VACCINE

High Dose (65+) Sanofi Pasteur	Lot # Exp 6/30/24 Sticker	Circle injection site Lt. DM Rt. DM	VIS Date 8/6/21	Administered by	Date
Fluzone (6m+) Sanofi Pasteur	Lot # Exp 6/30/24 Sticker	Circle injection site Lt. DM Rt. DM	VIS Date 8/6/21	Administered by	Date
<u>317 (NO INS.)</u> Fluarix (19y+) GSK	Lot # 554NM Exp. 6/30/24	Circle injection site Lt. DM Rt. DM	VIS Date 8/6/21	Administered by	Date

COVID-19 VACCINE

Pfizer 12y+	Lot # Sticker (can print lot #)	Circle injection site Lt. DM Rt. DM	VIS Date	Administered by	Date
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