

**DRUG TAKE BACK PROGRAM:**  
Bring any of your expired, un-  
used medication no questions



**Public Health**  
Prevent. Promote. Protect.

Coffey County Health Department

# **DRIVE- THRU FLU SHOTS**

**Coffey County Health Department Presents:**

**Seasonal Influenza Vaccine**

**Friday Oct. 7th-EMS Burlington 10:00am-1:00pm**

**Evening Clinics Available 5:30-6:30 Fire Stations**

Wednesday Oct. 5—Lebo

Monday Oct. 10—New Strawn

Wednesday Oct. 12— Gridley

Monday Oct. 17— LeRoy

Wednesday Oct. 19— Waverly

*\$25.00 for injection —6 months and older*

*High Dose \$50.00— **Only** available for 65 years and older*

*or present current insurance card*

*(we accept BCBS/Medicare/Coventry/ Kancare)*

***Consent form on back***



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# Coffey County Health Department Influenza Consent Form

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Street Address/ PO Box \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ County \_\_\_\_\_ Zip \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone# \_\_\_\_\_

Personal Physician \_\_\_\_\_

### *Please answer the following questions and information below*

- Have you ever had a flu shot before?-----yes \_\_\_ no \_\_\_
- Do you have a cold, fever, or acute illness?-----yes \_\_\_ no \_\_\_
- Are you allergic to chicken eggs or egg products?-----yes \_\_\_ no \_\_\_
- Have you ever had an allergic reaction to flu vaccine or Pneumococcal vaccine?—yes \_\_\_ no \_\_\_
- Have you been diagnosed with Guillain-Barre Syndrome?-----yes \_\_\_ no \_\_\_
- Do you have asthma \_\_\_\_\_—yes \_\_\_ no \_\_\_

*I hereby certify that the foregoing history is true and complete to the best of my knowledge and request and authorize receipt of the influenza vaccine. I verify that I have been offered a copy of the Vaccine Information Statement. I hereby authorize CCHD to release any information necessary to file a claim for payment to my insurance company. I acknowledge that I have reviewed a copy of CCHD's Notice of Privacy Practices with the effective date of April 14, 2003. I have been offered a copy of the Vaccine Information Statement. I have read, had explained to me and understand the information in the vis. I consent to inclusions of the immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below. VIS Date 08/2015*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## **THIS SECTION IS FOR CLINIC PERSONNEL USE ONLY**

<b>Payment Method:</b>
Cash/Check _____ BCBS _____ Medicare _____ KanCare _____ Coventry _____ Bill Employer _____

Cardholder Name \_\_\_\_\_ ID# \_\_\_\_\_

*(Exactly as it appears on card)*

Relationship of patient to cardholder: self child spouse other \_\_\_\_\_

	<u>Route</u>	<u>Lot Number</u>	<u>Exp Date</u>	Nurse Signature/Date
Multi Dose Sanofi-Pastur	LD RD	UI684AE UI678AB	06/30/2017	
Pre filled 36-Older Sanofi- Pastur	LD RD LVL RVL	UT5598KA	06/30/2017	
Pre filled 6-35 months Sanofi- Pastur	LVL RVL	UT5583KA	06/30/2017	
High Dose Sanofi Pasture	LD RD			
PPSV23(VIS 04/24/15)	LD RD			
PCV13 (VIS 11/05/15)	LD RD			