Drive– Thru Flu Shots

Coffey County Health Department Presents:

Seasonal Influenza Vaccine

5:30pm-6:30pm

Fire Stations

Consent on back -Please complete before arriving, including insurance information

Tuesday September 27th– New Strawn

Thursday September 29th– Gridley

Monday October 3rd– Lebo

Thursday October 6th– Waverly

Monday October 10th-LeRoy

Friday October 7th -Burlington

***Burlington's Clinic will be held from 11am-1pm**

Present current insurance card or payment of:

$45.00 for 6 months of age and older

$90.00 High Dose– ***Only*** *available for 65 years and older*

MEDICATION TAKE BACK–

Bring any expired, unused medications no questions

Coffey County Health Department
Influenza Consent Form

PLEASE COMPLETE BEFORE ARRIVING

Last Name ______________________ First Name ______________________ MI______

Mailing Address ____

City______________________ State____________ County________ Zip________________

Male_____ Female_____ Date of Birth_________________ Phone #____________________

Age__________ Personal Physician_____________________________

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
If you are 65 or older would you like the High Dose vaccine? ——————————-yes no

Cash/Check **Insurance Accepted:** BCBS Medicare KanCare Cigna Employer__________________________

Cardholder Name____ ID# ____

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 above. VIS Date 08/06/2021

Patient Signature____ Date__________________________

Pre-Filled 6 months and older Sanofi-Pasteur	Route LVL RVL LD RD	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications
FluBlok 18-64 yrs Sanofi Pasteur	Route LD RD	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications
High Dose 65– Older Sanofi Pasteur	Route LD RD	Lot Number	Exp Date	Nurse Signature/Date Verification of injection & review of contraindications