Wyoming Department of Health

Influenza Vaccination Intake Form 2023-2024

Please complete with information about the person who is receiving the vaccine.

Name: _____ **Birth Date**: _____ **Age**: _____ **Sex**: ☐M ☐F ☐Other

Race: ☐Asian ☐Black ☐Native American ☐Pacific Islander ☐White ☐Other **Ethnicity**: ☐Hispanic ☐Non-Hispanic

Mailing Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone: _____ **Email**: _____ **Wyoming Resident?** ☐Yes ☐No

Do you have Medicare or Medicaid? ☐No ☐Yes--Number:_____

Do you have insurance? ☐No ☐Yes Company:_____ Policy/ID#:_____Group#_____

If not you, please list: Does insurance cover the cost of the vaccine? ☐Yes ☐ No

Policyholder Name _____ **Date of Birth** _____ **Address**: _____

Screening Questionnaire & Vaccine Consent

1. Are you sick today? Do you have a fever?	☐Yes	☐No	☐Don't Know
2. Do you have an allergy to an ingredient of the vaccine?	☐Yes	☐No	☐ Don't Know
3. Have you ever had a serious reaction to influenza vaccine in the past?	☐Yes	☐No	☐ Don't Know
4. Have you ever had Guillain-Barré syndrome?	☐Yes	☐No	☐ Don't Know
5. Have you ever felt dizzy or faint before, during, or after a shot?	☐Yes	☐No	☐ Don't Know
6. Are you anxious about getting a shot today?	☐Yes	☐No	☐ Don't Know
7. If an adult, have you received a pneumonia vaccine? If yes, what year? PPSV23_____ PCV15 or PCV20_____	☐Yes	☐No	☐ Don't Know

By signing below, I consent to the _____ County Public Health Office (PHN) administering the current vaccinations to me. In addition, I read or have had explained to me and understand the Vaccine Information Statement(s) for the vaccine(s) that the PHN is administering today. A healthcare professional also provided education and counseling on each vaccine and thoroughly answered my questions. I have been advised to wait for 15 minutes of observation after receiving the vaccination(s).

Client/Guardian Signature: _____Date_____

Billing Authorization

By signing below, I authorize the PHN to bill my insurance company for the vaccine(s) administered to me. I also authorize the PHN to disclose my protected health information to my insurance company for payment purposes. I authorize my insurance benefits to be paid directly to the PHN.

Client Signature: _____Date_____

Receipt of the Notice of Privacy Practices:

The Notice of Privacy Practices explains how WDH may use or disclose information. Not all situations may be described. WDH is required to furnish its clients with a notice of privacy practices pertaining to information we use, maintain and disclose.

I have received a copy of the WDH Notice of Privacy Practices and have had an opportunity to ask questions regarding how my information will be used.

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

Client Signature: _____Date_____

Clinic Use Only

Booster Required? Yes No Date:_____

Vaccine:_____

Dose: ☐0.25ml ☐0.5ml ☐0.7ml High Dose

Site of IM injection: ☐RDT ☐LDT ☐RVL ☐LVL ***VIS/EUA Fact Sheet Provided:*** *Yes No* ***Lot number:*** _____

Dosage Schedule for Influenza Vaccine:	Age Group	Dosage Schedule
	9 Years and older	0.5ML: One dose
	3-8 Years	0.5 ML: One dose*
	6 Months - 35 Months	0.25 ML or 0.5 ML: One dose*†

** For children younger than 9 years of age, refer to the most recent ACIP Recommendations to determine the need for one or two doses. If two doses are needed, separate the doses by at least 4 weeks.*

†Dosage for age may vary by brand of vaccine. See package insert.

Signature & title of vaccine administrator: _____

Comments:

VFC Eligibility Screening: *(if any of the following apply, patient is VFC Eligible):*

☐ **Medicaid** ☐ **Uninsured** ☐**American Indian/Alaska Native** ☐**Under-Insured** (Insurance does not cover the vaccines needed)

If none of above, not eligible to receive VFC Influenza Vaccine.

Billed ☐ WYIR ☐