Public Health
Prevent. Promote. Protect.

Monroe County Health Department
118 Home Avenue
Woodsfield, Ohio 43793
740-472-1677 Ext 3

Date of Service_____

Patients Name	If under 18 – Parent/Guardian
Date of Birth/Age Male or Female	Phone #
Address	Billing: CASH☐ Insurance ☐ Medicaid ☐ Private ☐ Self Pay☐

Screening Questionnaire for Injectable Influenza Vaccination

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any questions it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, ask the provider.

1. Is the person to be vaccinated sick today? Yes☐ No☐ Don't Know☐
2. Does the person to be vaccinated have an allergy to eggs or to a vaccine component? Yes☐ No☐ Don't Know☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past? Yes☐ No☐ Don't Know☐
4. Has the person to be vaccinated ever had Guillan-Barre syndrome Yes☐ No☐ Don't Know☐

Signing below confirms that I have received a copy and have read or had read to me the Vaccine Information Statements about influenza vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of influenza vaccine and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request. I also grant permission for the record to be released to physician providers, health departments, schools, daycare or preschool center, state immunization registry databases and others as is necessary. I agree to the terms of the Monroe County Health Department Notice of Privacy Practices and understand that I may request a copy free of charge.

For Medicare Part B and all insurance recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment to the party accepting assignment.

I give permission to the Monroe County Health Department to bill my insurance and I accept the responsibility for my balances, co-pays or deductibles. If I am self pay, I will be responsible for the fee charged for each vaccination given. (REV. 10/2019)

Signature:_____Date:_____