



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	Phone #
Male or Female	
Address	Billing: CASH or Insurance (copy card) () Medicaid () Private () Self Pay

Screening Questionnaire for Injectable Influenza Vaccination

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.

yes no don't know

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 an ingredient of the vaccine? 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 Guillain Barré syndrome? yes no don't know

5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot? yes no don't know

6. Is the person to be vaccinated anxious about getting a shot today? 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: _____

Office Use Only

CPT	Immunization Service	DX
90670	Pevnar 13 Ped/Adol () Adult ()	Z23
90732	Pneumococcal-Pneumovax23	Z23
90672	Flumist	Z23
90685	Influenza:6-35 month PFS Quad	Z23
90686	Influenza: >3 years PFS Quad	Z23
90662	Influenza High Dose	Z23
90460	Administration of Vaccine (Child)	Z23
90461	Additional Toxoid Component	Z23
90471	1 st Admin of Vaccine Adults/Ins	Z23
90472	>2 Admin of Vaccine Adults/Ins	Z23
99211	Nurse-Minimal Vist/office	Z23

Office use only:	
Payment Method: () Self Pay () Insurance () Medicaid () MCO () Medicare () HMO	
() Ins. Verified/Active () Ins. Verified/Non-Active	
() Agency _____ () Other _____ Sliding Fee () 0% () 20% () 40% () 60% () 80% () 100%	
() VFC () Vaxcare () Private Purchase () ODH Vaccine () Other _____	

Date	TOTAL CHARGED \$	Payment
Payment Date	Payment Amount	Balance
() Billed	() Impact Updated	() Paid
		Check/Cash

Nurse signature _____ Date _____

Date Administered	Type	Site of Injection	Lot Number	Manufacturer	VIS Date
		RD IM LD IM			
		RVL IM LVL IM			