☐ CHILD HEALTH ☐ ADULT HEALTH

Vaccination Form - Statement of Understanding, Permission & Assignment

Harnett County Department of Public Health

1. Last Name _____ First Name _____ MI _____
2. Social Security Number (**ONLY IF NEEDED FOR BILLING**) _____
3. Date of Birth _____
4. Race ☐ 1. White ☐ 2. Black ☐ 3. Am Id/Alaskan Native ☐ 4. Asian/Pacific Islander
   Ethnicity Hispanic Origin? ☐ 1. Hispanic/Latino ☐ 2. Not Hispanic/Latino ☐ 3. Declined
5. Sex ☐ 1. Male ☐ 2. Female
6. County of Residence _____ ☐ ☐ ☐
7. Street Address _____
8. City, State, Zip _____
9. Telephone Number _____
10. Medicare Number _____
11. Medicaid Number _____
12. Private Insurance Number / Subscriber# / ID# _____

INSURANCE COMPANY:

STATEMENT OF UNDERSTANDING: I have read and I understand the information provided to me about receiving vaccines for influenza and pneumococcal pneumonia, and I have had the opportunity to ask questions. I understand that being allergic to eggs may be a reason for not receiving the influenza vaccine. I affirm to the best of my knowledge that the following questions have been answered truthfully.

1. Are you allergic to eggs? ☐ Yes ☐ No
2. Do you now have a fever with a temperature above 100°F? ☐ Yes ☐ No
3. Have you had a serious allergic reaction to influenza vaccine? ☐ Yes ☐ No

☐ ☐

STATEMENT OF PERMISSION & ASSIGNMENT: By placing my initials in the space(s) provided, I voluntarily give my permission to receive (initials) _____ influenza vaccine. I understand that payment for this service may be made in accordance with the provisions of Title XVIII of the Social Security Act (Medicare), and/or Title XIX of the Social Security Act (Medicaid); and/or private insurance or other third-party payor. I hereby authorize the provider of service to release information necessary for the processing of any claim for payment made on my behalf, and I authorize payment to the provider for such claim.

NOTICE OF PRIVACY PRACTICES:

By signing below, I am acknowledging that:

☐ 90662 Fluzone Quad HD ☐ 90686 QUAD ☐ 90756 Multi
☐ 90674 Flucelvax

- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for Harnett County Health Department; and
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

X _____ **X** _____

Signature of patient or parent/legal guardian/legally responsible person **Date**

Description of relationship to patient

DO NOT WRITE BELOW THIS LINE

For Provider Use Only:

Influenza Vaccine Mfgr./Lot Number _____

Injection Site: _____ Right _____ Left Deltoid Date _____

Administered by _____
Signature

Patient
FLU ONLY