☐ 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 the vaccine for influenza, 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: I voluntarily give my permission to receive the 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:

- I am either the patient or the patient's personal representative;
- HCHD's "Notice of Privacy Practices" has been made available to me to view and I may request a copy at any time.
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

☐ 90686 Fluzone & Flulaval ☐ 90694 HD FLUAD ☐ 90756 Flucelvax

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 Mfgr./Lot ______________ Vaccine Number

Injection Site: ______ Right ______ Left Deltoid Date ______________

Administered by ______________

Signature

Patient FLU ONLY