Wyandot County Public Health
Seasonal Influenza (Injectable) Administration Record
Patient Financial Responsibility Form

PLEASE PRINT CLEARLY			
Last Name	**First Name**		**M.I.**
Address	**City**	**State**	**Zip**
Phone Number	**Parent/Guardian Name (only if client is under age 18)**		
Birth Date	**Age**	**Sex**	Male Female

Please answer the following questions:	**Circle One**	
Is the person to be vaccinated sick today?	YES	NO
Has the person to be vaccinated ever had a serious reaction to influenza vaccine?	YES	NO
Does the person to be vaccinated have an allergy to eggs, latex, or other vaccine component?	YES	NO
Has the person to be vaccinated ever had Guillain-Barre` Syndrome?	YES	NO

I have read or have had explained to me the information regarding influenza disease and the influenza vaccine. I had the opportunity to ask questions that were answered to my satisfaction and received a Vaccine Information Sheet. I believe I understand the benefits and risk of the influenza vaccine and ask that the vaccine be given to me or the person named above for whom I am authorized to make this request. I understand information regarding my vaccine may be transferred to the Ohio Department of Health Immunization Program. I acknowledge that I have been offered or received a copy of the notice of privacy practices for Wyandot County Public Health (WCPH). I give my consent to use and disclose my protected health information for the purposes of treatment and payment of my health care. My signature is also agreement to provide payment of all charges at the time of service.

Patient or Guardian Signature_____

Date Signed_____

For Office Use Only		
INSURANCE		**SELF-PAY**
	Medicare (Traditional Part B) ID#_____	☐ Cash
	Medicare HMO (ex. Anthem Medicare Advantage, Aetna Medicare Advantage)	☐ Check #_____
	Name of plan:_____ ID#_____	☐ Credit Card
	Medicaid (ex.Traditional Medicaid, CareSource, Molina, Buckeye, Paramount)	Type_____
	Name of plan:_____ ID#_____	CC#_____
	Private Insurance Company Name_____	Exp. Date_____
	Member ID:_____Group:_____Plan:_____	Amount:_____
	Policy Holder Name & Date of Birth:_____ ___/___/___	Receipt #_____
	Relationship to Policy Holder:_____	Received by:_____

For Office Use Only

Vaccine Administered Information

Date	Vaccine Name	Vaccine Lot #	Exp. Date	Mfg.	IM Site	Dose	Staff initials
			6/30/2022	Sanofi Pasteur		0.5 ml	

Children 6 months - 8 years: Initial Dose Booster Dose Previously Vaccinated

VIS: 8/06/21